

The Diagnosis, Prevention and Treatment of Pertussis

Lyons P. Strean, M.Sc., Ph.D., D.D.S., F.A.P.H.A.

In a report published by the Council on Pharmacy and Chemistry of the American Medical Association¹ based on well-controlled studies in widely separated centers in the United States and Canada, the conclusion was drawn that pertussis bacterial vaccines were only 60% effective when used for active immunization against pertussis. These results confirmed the view held by the author who for the last nine years has carried on laboratory and clinical investigation with a view to producing agents which would be effective not only for prevention of pertussis but also for the diagnosis and treatment as well.

Since immunity against diphtheria and tetanus is produced by toxic fractions of the respective organisms associated with these diseases and not by bacterial vaccines or antibacterial serum, it would seem logical to utilize, as an immunizing agent against pertussis, the endotoxin fraction of *H. pertussis* known to play a significant role in producing the clinical manifestations of this disease. With this end in view three products were developed, the Strean Skin Test, an endotoxin for testing immunity against pertussis, pertussis endotoxoid-Vaccine for prevention and antipertussis serum for treatment. The latter is a rabbit pseudoglobulin refined and concentrated and contains not only antiendotoxic antibodies but also antibacterial.

Diagnosis

The importance of diagnosing pertussis in the incubation or catarrhal stages cannot be over-emphasized. Waiting for the whoop to develop means inviting dangerous sequelae in the exposed child. The epidemiologist will agree that outbreaks of pertussis can be averted by early diagnosis and treatment. Unfortunately the available means for diagnosis are not often used. Pathognomonic of pertussis is the presence of a high lymphocyte count, the isolation of *H. pertussis* on a cough plate or naso pharyngeal swab, and the absence of pertussis antiendotoxin in the blood stream. These three significant points alone are sufficient to diagnosis pertussis with certainty. The intramuscular injection of 10,000 provisional units of antipertussis serum containing both fractions, antibacterial and antiendotoxic, will almost invariably reduce the lymphocyte count from about 70% to around 30% in from 24 to 48 hours, if the child is in the incubation or catarrhal stage.

Isolation of *H. pertussis* on a Bordet-Gengou plate has always been a difficult task, because the contaminating organisms overgrow *H. pertussis* and render the plate useless for diagnostic purposes. About 50 to 100 units of penicillin streaked over the blood plate when being seeded will inhibit most contaminants and permit *H. pertussis* to grow in pure culture. The tiny, shiny, almost translucent colonies with zones of hemolysis are easily recognizable. Stained smears of these colonies will show them to be short gram negative rods.

Prevention

Active immunization against pertussis has not proved to be as effective as the tried and proved agents against diphtheria and tetanus. The reason for this failure may be attributed to the lack of certain necessary factors in the vaccines customarily used. Since *H. pertussis* phase I contains a potent endotoxin which is released when the cell autolyzes, it would seem reasonable that this toxin should be incorporated in the vaccine. For the prevention of diphtheria and tetanus one uses toxoids and not bacterial vaccines. In pertussis why not use endotoxoid when we know that the bacterial vaccine is only 60% effective? A suspension of *H. pertussis* vaccine in pertussis endotoxoid should afford more effective immunization by this double-barreled principle since by the one antibodies are produced against the invading organisms and by the other neutralizing substances against the endotoxin. Ninety billion organisms suspended in 900 provisional units of pertussis endotoxoid has proved about 95% effective in clinical trials over a period of five years.

It might be argued that the Sauer and Kendrick types of pertussis vaccines contain the endotoxic principle since they are prepared from phase I organisms. This is an erroneous conclusion because Sauer vaccines are preserved with phenol and such agents as phenol, acetone and alcohol are known to destroy the antigenic quality of the endotoxin. Furthermore the amount of endotoxin capable of being released from even 100 billion organisms would be insufficient to immunize children effectively based on the anti-endotoxic titer.

Vaccines made from organisms grown in semi-synthetic liquid media are not very satisfactory, since the organisms grown in this medium seem to lose their virulence and ability to produce

potent endotoxins. Hornibrook of the National Institute of Health, Bethesda, Md., described this medium for growing *H. pertussis* yet most manufacturers have avoided its use in the preparation of pertussis vaccines.

The time interval between injection should be about two weeks since pertussis endotoxoid is slow in producing antibodies and by attempting to force immunization with a shorter interval one merely succeeds in reducing the response. The law of "diminishing returns" is particularly applicable in this instance.

Treatment

The use of convalescent serum in the treatment of pertussis has not proved very satisfactory even when large volumes are injected. Such serum contains antibacterial antibodies usually of high titer if taken from recently recovered cases. Despite the high agglutinin titer such serum is relatively ineffective if given after paroxysms have made their appearance. Some benefit may be derived if given in the preparoxysmal stage. Since the paroxysms are due to the endotoxin because at the height of the paroxysmal stage when the child is in greatest distress, cough plates are substantially negative due to autolysis of the organisms, it would seem reasonable to inject antiendotoxin. But antiendotoxin is of low titer in convalescent serum; therefore huge quantities would have to be injected for the desired therapeutic effect. Rabbits hyperimmunized with pertussis endotoxoid-vaccine produce antibodies of high titer. These antibodies contain both the antibacterial and the antiendotoxic principles. In over 5,000 children treated in either paroxysmal or preparoxysmal stage the results were dramatic in most instances, that is, a marked reduction in the frequency and severity of paroxysms in about 96 hours after serum administration. This is accomplished in most instances with one intramuscular injection of 10,000 provisional units of antipertussis serum (10 cc.). Reactions, local and general, are usually very mild if present at all. Allergic manifestations to rabbit protein is transient and usually no cause for concern, though the conjunctival or intradermal test is recommended prior to its use.

Hyperimmune human serum unrefined and unconcentrated or the refined and concentrated globulin, contain only antibacterial antibodies; consequently are ineffective for use when the toxin requires neutralization. One does not use antibacterial serum against diphtheria or tetanus and these diseases are known to be produced by bacteria. Antitoxin is the recognized therapeutic agent. Thus it would appear logical to use an antiendotoxin against pertussis when the clinical manifestations of the disease are known to be produced by the endotoxin. However, since the

patient may present itself for treatment in the preparoxysmal stage when the organisms predominate or in the paroxysmal when the endotoxin predominates, it would appear reasonable to immunize against the living organism and its endotoxin.

Discussion

The Schick and Dick Tests are valuable diagnostic aids in the treatment of diphtheria and scarlet fever. Likewise the Strean Test can be used in testing immunity to pertussis. Children immunized with pertussis bacterial vaccine (Sauer or Kendrick) will possess in their serum antibacterial antibodies only. Therefore, such children usually show a positive skin reaction to the Strean Test. However, children immunized with pertussis endotoxoid-vaccine usually show a negative reaction within a few months after the course of immunization has been completed. Reversal of the Skin Test from positive to negative, like the Schick and Dick Tests, is an indication of immunity. Likewise, in the treatment of the active cases of pertussis the Skin Test is reversed in 24 hours from positive to negative when an adequate dosage of antipertussis serum containing the antiendotoxin principle has been administered.

Pertussis endotoxoid-Vaccine has in the past five years reduced the incidence of pertussis 95% in the injected group when compared with a similar number of controls handled under similar conditions. In fact in one institution where an outbreak of pertussis occurred, children immunized with pertussis endotoxoid-vaccine one, two and three years previously were permitted to sleep and play with children having the clinical manifestations of the disease. Though definitely exposed none of these children came down with pertussis.

Booster doses of endotoxoid-vaccine are recommended once a year (2 cc.) until school age.

The incidence of pertussis can be materially reduced if pregnant mothers are immunized in the second trimester. Their offspring would be relatively immune for the first six months of infancy when the mortality rate is at its highest. At the age of six months the infant is given a course of immunization with pertussis endotoxoid vaccine and booster doses given subsequently once each year until the school age. Those coming down with pertussis should be treated early with adequate dosage of antipertussis serum containing both antibacterial and antiendotoxic principles.

Pertussis, at present, is the killer of infants and the precursor to bronchiectasis. This state of affairs can be changed so that pertussis would hold out no greater fear than diphtheria and smallpox.

Medical Critique

The First of a Series by John McEachern, M.D., F.A.C.P., F.R.C.P. (Can.)

1. On The Stethoscope

Plutarch said that, "The life of a vestal virgin was divided into three parts; in the first of which she learned the duties of her profession, in the second she practised them, and in the third she taught them to others."

This is no bad model for the life of a physician. This in spite of the fact that the trend today is to learn, then teach and in the course of time when old and gray to turn for various reasons to the practice of the art.

The role of the experienced practitioner in the teaching of medicine has been somewhat neglected. The emphasis weighs heavily in favour of youth, science and the ancillary medical subjects. Whether this is right or wrong remains to be seen but the art of medicine is not yet dead, nor is experience still a poor teacher.

William Heberden (1710-1810) once wrote that the practice of medicine has been more improved by the casual experiments of illiterate nations and vagabond quacks than by the reasonings of all the celebrated and theoretic teachers of it; very few of whom have furnished us with one new medicine or in any one instance at all improved the art of curing disease.*

Such a statement, of course, would be modified today but there remains much truth in it.

The stethoscope was the first valuable diagnostic instrument to be discovered. In 1819 Rene Laennec wrote as follows, "I was consulted by a young woman labouring under the general symptoms of a diseased heart, and in whose case, percussion and the application of the hand were of little avail on account of the great degree of fatness.

"The other method (direct application of the ear) being rendered inadmissible by the age and sex of the patient, I happened to recollect a simple and well known fact in acoustics, and fancied at the same time that it might be turned to some use on the present occasion. The fact I allude to is the augmented impression of sound when conveyed through certain solid bodies, as when we hear the scratch of a pin at one end of a piece of wood on applying our ear to the other.

"Immediately, on this suggestion, I rolled a quire of paper into a sort of cylinder and applied one end of it to the region of the heart and the other to my ear, and was not a little surprised and pleased to find that I could thereby perceive the action of the heart in a manner much more clear and distinct than I had ever been able to do by the immediate application of the ear.

"From this moment I imagined that the circumstances might furnish means for enabling us to ascertain the character not only of the action of the heart but of every species of sound produced by the motion of all the thoracic viscera."

This brilliant discovery of Dr. Laennec was of the utmost importance. The master knew and emphasized the limitations of this method and many careful physicians followed in his footsteps. But alas! hundreds who flocked to his clinics for short courses withdrew to spread ignorant and evil prognostications throughout Europe and America.

The stethoscope replaced the five senses in the examination of the patient. One hundred and thirty years later one sees students and physicians reach for their stethoscope before they have even looked at the patient or taken a careful history.

Here is what Laennec said about the practise of feeling the pulse. If he were alive today he would probably say much the same about the usage to which his own invention has been put by those still unversed in its ways.

"It is surprising that the practise of feeling the pulse has been so generally followed in all ages. The reason of this practise is, however, sufficiently obvious: it is of easy performance and gives little inconvenience either to physician or patient. The cleverest, it is true, can derive from it but a few indications and uncertain conjectures; but the most ignorant can, without exposing themselves, deduce from it all sorts of indications. Its very uncertainty gives it a preference with persons of inferior qualifications, over other means quite certain in their nature, and which enable the non-professional observer to judge of the skill of the physician by the correctness of his diagnosis and prognosis."

We might today apply these remarks with few alterations to the "cardiographers" who with little training and no experience are abusing the science of electrocardiography today.†

The unsatisfactory state of the art of auscultation is due in no small part to the fact that physicians have not trained themselves in the method. Nor is there any way in which a teacher may assess what is going on between the ear pieces of the student's stethoscope.

One has watched senior students and physicians listen intently to a perfectly simple murmur for long periods of time. At the end it was obvious that they were hopelessly at sea.

There was no appreciation or familiarity with various sounds and murmurs. There was no sense of timing, no appreciation of pitch or tone.

These senses may all be developed but they must be studied and learned by the individual. How few bother to do this.

Alas, if these things are not learned the instrument becomes but a mask for the physician's ignorance. One hopes that the day of the shirt button doctor is about over. It was not an uncommon practise fifteen to twenty years ago for some doctors to make an insurance examination by unbuttoning one shirt button and inserting the stethoscope through this aperture. The patient was perhaps satisfied as he no doubt imputed some magical power to the instrument, the doctor collected his \$5.00 and the only one who stood to lose was the insurance company.

Some years ago I was informed by the medical director of a large company that a number of their former examiners invariably recorded the blood pressure of applicants as 120/80. On investigation a number of these gentlemen were found to have no blood pressure instruments at all. Is it any wonder that some companies now write policies up to \$10,000 without a medical examination?

I would suggest that if auscultation be considered of value in diagnosis that our students be given some training in the science of acoustics; in the appreciation of pitch and tone and especially in timing the sounds to which they listen. No known methods of recording clinical sounds have yet proven reliable.

One might also suggest that every student and every physician have an audiogram periodically to measure his auditory acuity. This is done routinely with every member of the R.C.A.F. Even then there is no way of estimating the qualities of judgment or common sense used by the physician in the interpretation of his aural perceptions.

And it is through lack of just these qualities that so many ghastly errors are made, with irreparable effect upon the psyche of the patient.

When the diagnosis of heart disease is based on auscultatory findings alone—beyond all doubt—on the average it is a modest 75% wrong if the patient is under 40 years of age.

In other words 75% of such patients who have been told that they have heart disease and who seek other opinion have no real organic trouble at all.

Such false diagnoses are usually retailed (plus the 3 cent cheque tax), and I mean retailed to the patient as "a leaking valve" or "your pulse is too fast" or you have an "irregular heart."

Experience based upon over 3,000 autopsies personally performed in which the histories were available has taught me that in the best or worst hands the stethoscope, and its masters, are at least 50% wrong in cardiac cases.

This is the old story of over-diagnosis and until more exact methods of study are developed perhaps in the field of acoustical engineering one fears such errors will continue unless the practitioner takes the trouble to learn the method.

Strangely enough in the case of respiratory diseases the stethoscope has found its home niche due to the diagnostic value of the X-ray. Unfortunately one cannot confirm normal or abnormal heart sounds by means of the Roentgen ray.

No one would now dare to diagnose pulmonary tuberculosis entirely by the auscultatory method except in very advanced cases. On the other hand, in the diagnosis of cases of pulmonary sepsis or early bronchiectasis it is one of our best aids. In fact, the X-ray may be quite negative in the presence of gross disease of bronchiolar tree.

It is truth when one says that a diastolic murmur means organic heart disease and yet how many physicians have developed the sense of timing of heart sounds sufficiently well to recognize this type of murmur?

During the course of an argument with some medical directors of insurance companies two years ago about the stupidity of companies rejecting applicants solely on account of systolic murmurs, one of them said, "Doctor, if we were quite certain that all our medical examiners could actually recognize a diastolic murmur we would accept all the cases with systolic murmurs in Canada as first class risks." This still remains the perfect answer.

One might record certain clinical impressions about the value of the stethoscope in the diagnosis of cardiac disease.

Value of the auscultatory method in the diagnosis of organic cardiac disease:

1. Specific Value—Recognition of diastolic murmurs, pericardial friction rubs and certain disorders of rhythm; the latter may be confirmed on an electrocardiogram.

2. Questionable Value unless confirmed by, or corroborated by other methods.

Disorders of rhythm, such as auricular flutter or ventricular tachycardia which should be confirmed by an EKG.

3. Doubtful of any value per se (without other evidence) in the evaluation of systolic murmurs of any kind, differences in intensity of heart sounds, gallop rhythm, reduplicated sounds, and all the other unimportant extraneous cardiac sounds described in the current text books and medical literature.

In conclusion a few personal postulates upon this subject may be of value, namely:

1. That the stethoscope merely brings the ears closer to the origin of the body sounds.

2. That though such sounds may be increased in intensity they must still be interpreted.
3. That the method of interpretation is learned only by experience, and its value must be assessed only in conjunction with other clinical methods.
4. That in only a few instances (e.g., mitral stenosis) is it possible to make an **etiological** cardiac or respiratory diagnosis by ear alone.
5. That a diagnosis made by the stethoscope alone is frequently erroneous.
6. That our ears alone cannot assess the functional capacity of an organ.
7. That the most vital part of the stethoscope

lies between the ear pieces when applied to the head.

8. That the physician must know the wide variations of the normal person in all fields.

9. That the study of the patient as a whole, is the prime function of a good physician. A study in which all the physician's senses, skill and humanity are employed to detect the abnormal in those who consult him voluntarily and in good faith.

* Heberden gave us the first and best description of Angina Pectoris.

† This subject has been ably discussed by Willius, C.M.A.J., March, 1946.

Diagnosis of Injured Knee Cartilages

Third Paper of a Series by Henry Funk, B.A., M.D., Ch.M.

Demonstrator in Orthopaedics, University of Manitoba. Orthopaedic Consultant to Ninette and St. Boniface Sanatoria

Medial cartilage of the knee is injured six to eight times as frequently as the lateral cartilage. Anatomically there seems to be no good reason for this, but a mechanical explanation for the greater frequency of medial cartilage injury lies in the fact that it is subjected to greater and more frequent strain.

The manner of injury in the case of the medial cartilage is through abduction with external rotation of the tibia on the femur; in the case of the lateral cartilage by adduction with internal rotation. These manoeuvres suck the respective cartilage into the joint space and may tear it loose at or near the periphery. Or if the cartilage becomes engaged between the articular surfaces of the condyles of the femur and tibia a transverse or oblique break may be produced. However, there are other ways in which the cartilage may be injured, such as direct violence resulting in dislocation of the knee joint, fracture, etc.

Types of Injuries

In the main there are two types of injury, **Transverse and Marginal**, with variations of these types. The transverse injury, frequently referred to as a fracture, may occur in any part of the cartilage and permits one or both of the free ends to become engaged between the bones. Theoretically this type should yield to manipulative reduction. In the marginal type the cartilage is torn along a line parallel with the periphery and permits of a bucket handle type of displacement. If the free margin slides across the joint into the intercondylar space a persistent blocking occurs which is not amenable to manipulation.

Clinical Features and Tests

While the mode of injury seems to be fairly readily explained, to make a positive diagnosis may be most difficult. Unfortunately no test will

determine with absolute certainty in all cases whether or not a cartilage is injured.

A careful history may be invaluable in arriving at the correct diagnosis and should always be taken in detail. In a typical case the patient gives a history of injury in which the knee has been twisted resulting in a swollen, painful joint with limited extension for a week or two. The extension is limited not only by pain but by a feeling of elastic resistance as well. Subsequently, incidents of "something slipping in the joint" (often described as a dislocation) occur, during which extension may again be limited for a variable time. Usually the patient volunteers that he has been able to restore full extension by applying force to the anterior aspect of the knee and with a definite clunk or jarring sensation the knee is forced into complete extension. At times the knee remains blocked against full extension and no applied force overcomes it. A point of tenderness is complained of somewhere along the cartilage, the site of attachment of the anterior horn being most common and being situated just medial or lateral to the patella for its respective cartilage. There may also be complaint of progressive weakness of that extremity and instability of the knee joint.

Inspection of both lower limbs frequently yields much valuable information. The affected limb may display marked atrophy of the thigh; the knee may be enlarged and the joint held in a semi-flexed position. However, these are factors which may be present in any diseased joint.

The amount of atrophy, if any, cannot be determined by inspection and should be done by measurement. Estimating enlargement of the knee is simple as the patella serves as a definite landmark. But to guess at relatively similar points on the two thighs can lead to gross error. A point should be taken on the anterior surface

of each thigh equidistant from its respective anterior superior iliac spine and the limbs measured there. Thus any degree of atrophy can be satisfactorily determined.

Having determined the amount of atrophy, the next thing is to test the strength of the quadriceps. The patient holds his knee in strong extension and the examiner attempts to flex the knee against the patient's resistance. If considerable weakness exists as compared with the unaffected limb the examiner can readily detect it.

Range of movement of the joint is tested and compared with the normal joint. Disparity between the two joints is best estimated by use of a goniometer, which is a protractor with two arms attached. This serves to eliminate guesswork and provides accurate records for future comparison.

Only a few seconds are required to test the cruciate and collateral ligaments. The former is checked by flexing the knee to about 100° and alternately pulling forward and pushing backward on the upper end of the tibia on the femur—the so-called "Drawer sign." The collateral ligaments are tested by flexing the knee 5° to 10° and abducting and adducting the tibia on the femur—the rocking sign—always comparing these movements with the well limb.

Presence of excess fluid in the joint is readily determined by balottment of the patella on the femur. Similarly, the presence of undue local heat in comparison with the well joint is noted. Points of tenderness are noted, the commonest sites, as previously stated, being at the attachment of the anterior horns.

Testing for abnormal mobility of the cartilages is done with the patient supine on a rigid examining table, and with the examiner standing on the affected side of the patient, facing his head. The procedure, in the case of the right knee, is to grasp the lower leg in the examiner's right hand, the left palm is placed on the knee, the index finger is used to palpate the medial cartilage and the thumb to palpate the lateral cartilage. With the knee flexed as acutely as the patient will permit, the leg is alternately rotated outwards and inwards in a sort of circumductory movement. This alternately places the cartilage under tension and sucks them into the joint. The injured cartilage may be felt to "pop" in and out under the palpating digit. Also there may be an associated click as the cartilage "pops" out.

Failing this, to test for the medial cartilage, the knee is acutely flexed, the leg strongly rotated outward, abducted on the femur and the joint fairly rapidly extended, the index finger constantly palpating the cartilage. At a certain point a "clunk" may now be felt as the cartilage is forced out from between the bones. This is often audible and produces a jarring sensation. For the

lateral cartilage the leg is strongly rotated inwards, adducted on the femur and the knee extended with the thumb as the palpating digit. This is the McMurray sign. If and when the "clunk" occurs, the patient may experience a variable amount of pain which may be almost excruciating.

In the supine position both the knee and hip are flexed in conducting this test and usually the patient is all too co-operative, assisting every movement. The examiner has his hands full maintaining the proper position of the leg, and the patient's assistance may defeat proper execution of the test. To eliminate this co-operation and exclude hip movements I have found it useful to turn the patient on his face and reapply the test. In this position the finger and thumb encircle the joint from the posterior aspect. Usually there is no resistance or assistance on the part of the patient and a positive test may be elicited when it was negative in the supine position.

Eliciting a definite "clunk" is quite significant but a much less palpable or audible click must not be confused with one frequently occurring in normal joints so that for comparison the other joint must always be tested. In lax-jointed individuals especially this may be the case and be quite normal. Also a discoid cartilage—consisting of a cartilage covering the whole articular surface of the tibial condyle in place of the normal rim of cartilage—may be excessively mobile and suggest an injury.

X-Ray—Taking X-ray films pre-operatively should be a "must" but is valuable only from a negative standpoint. The cartilage casting no shadow provides no information unless a contrast medium, such as air, is injected into the joint. This is quite a technical procedure and certainly not warranted as a routine measure. The main object of the X-ray film is to eliminate other pathology, particularly loose body or bodies and osteochondritis dessicans. These may produce symptoms very similar to those of an injured cartilage and before exploring a joint it is always well to know precisely what to expect. A sesamoid bone in the posterior aspect of the joint must not be mistaken for a loose body.

Differential Diagnosis

It is not in the scope of this paper to go into the detail of differential diagnosis. Suffice it to mention a few of the commoner conditions for which an injured knee cartilage may be mistaken. One point worthy of mention is that pain in the knee may not be indicative of any pathology in that joint and if the joint is negative to examination one must not lose sight of the fact that the pain may be referred from the hip joint.

indicating the importance of testing the hip joints as well.

Osteochondritis Dessicans

This occurs when a fragment of articular cartilage with its corresponding cortex becomes deprived of its blood supply. At first it remains in situ but the patient complains of pain in the knee, particularly in relationship to certain movements. Clinically, the joint appears normal but the X-ray film clearly demonstrates this defect.

Loose Body or Bodies

These may have their origin from: 1. Osteochondritis Dessicans. 2. Osteo-arthritis leading to detachment of a marginal osteophyte. 3. Chondrification of the synovial membrane leading to formation of multiple loose bodies—Osteochondromatosis.

The history of injury and swelling is absent but blocking is a very frequent occurrence and may occur under almost any circumstances. The blocking does not persist and the patient may have been able to palpate the loose body subcutaneously in various locations, even in the suprapatellar region. Here the X-ray film is all important both in determining the number of bodies and their location, although the location varies from time to time.

Wartime Prices and Trade Board Bulletin to Doctors on Extra Rations

Ottawa, March 20—For the benefit of those doctors who wish to obtain extra rations for their patients, the Wartime Prices and Trade Board has issued a reminder that the doctor's statement to the Board must contain the following information: Name and address of the applicant, name of the disease, kind and amount of rationed food over and above the regular ration, the length of time these extra rationed foods will be necessary and the age of the patient, if under sixteen.

The Ration Administration has experienced considerable difficulty in complying with doctors' requests for extra rations when complete information as to their patients' requirements has not been given. For example, a doctor will write in to the Ration Office saying that Mrs. Jones needs extra sugar because she has a certain ailment, but there is no indication as to how long the patient needs the extra sugar or how much she needs, etc.

For those doctors who are not familiar with the amount of sugar, corn syrup, or other preserves which each ration book holder may obtain without any extra requisition, the Board has

Tuberculosis of the Knee Joint—While this does not require differentiation very often, occasionally a patient presents himself with a history very similar to that of an injured knee cartilage. And at times it is impossible to arrive at the correct diagnosis even by exploring the joint.

Muscle atrophy is usually evident not only above the joint but below it as well. There is a general synovial thickening and local heat. McMurray's sign is absent but periodic or persistent blocking may be present. The X-ray film may show narrowing of the joint space or even some subchondral cortical destruction but in early cases this is not present. A tuberculin test may be helpful but the absence of a negative reaction does not exclude tuberculosis. Aspiration of the intra-articular effusion with guinea-pig inoculation, too, may be misleading since it may be negative and so it may be necessary to wait until the X-ray film gives positive proof.

It is not the purpose of this paper to deal with treatment but apart from certain marginal tears there is no treatment other than surgery. Such surgery should only be attempted where a rigid aseptic technique can be carried out. The layman is frequently misled into believing that a stiff joint will ensue but in the absence of infection this risk has been reduced to nil.

drawn attention to the fact that each sugar-preserves coupon is worth one pound of sugar or any one of the following: 30 fl. oz. of blended table syrup, cane syrup or corn syrup, two quarts of molasses, 24 fl. oz. of jam, jelly or marmalade, four pounds of maple sugar, or 80 fl. oz. of maple syrup until May 31st, and 48 fl. oz. after that date.



"Courage and Devotion Beyond the Call of Duty"

Through the co-operation of Mead Johnson & Company, \$34,000 in War Bonds are being offered to physician-artists (both in civilian and in military service) for art works best illustrating the above title.

This contest is open to members of the American Physicians' Art Association. For full details, write Dr. F. H. Redewill, Secretary, Flood Building, San Francisco, Cal.

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Cocksurenness in diagnosis is the vice of the inexperienced; excessive caution that of the mar who has seen too much.—Robert Hutchison.

Pathological Lesions of the Appendices Epiploicae

With a Report of One Case of Torsion, Roy P. Brown, M.D., L.M.C.C.

Pathological lesions of the appendices epiploicae are not very common. However, after reading Dr. Markovits' case (Man. Med. Rev. 25: 547, 1945), and having had a case of my own at about the same time, I thought it might prove interesting to present some of the salient points concerning these ordinarily innocuous blobs of fat.

Anatomy

The appendices epiploicae are small pouches of peritoneum filled with fat and situated along the colon. They are best marked on the transverse and pelvic portions. Most of them are attached to the colon between the "inner margin" and the anterior taenia, but on the iliac and pelvic colon they are in two rows, one on each side of the anterior taenia. As many as three rows have been observed. They may occur on the caecum and appendix but have not been seen on the rectum. The number of appendices varies in wide limits, but in round numbers an adult usually possesses about one hundred. In form they are irregular, being usually sacculated or conical. Their size tends to vary with the state of nutrition of the individual.

Histologically, in addition to serous covering and fatty content, there is a variable amount of reticular and elastic tissue and a few small blood vessels. The blood supply is from branches of the superior and inferior mesenteric arteries which enter at the bases and extend to the extremities. The veins follow the same course as the arteries and empty into the superior and inferior mesenteric trunks.

Appendices epiploicae are not universally present in vertebrates. They are absent in cows and sheep and only rudimentary in dogs, cats, and rabbits; while in anthropoid apes they are well developed.

Pathology

The chief pathological conditions are (1) torsion, (2) acute inflammation, (3) detachment, and (4) the formation of adhesions. (1) **Torsion** may be sudden or gradual—each process resulting in a different clinical picture. Sudden torsion gives rise to congestion of the enclosed fatty tissue with or without subperitoneal hemorrhage; or it may result in necrosis with complete gangrene. Gradual torsion gives rise to a chronic inflammatory process which may have much in common with ischaemic fat necrosis; occasionally resulting in calcification or cyst formation. (2) **Acute Inflammation** is due to infection usually arising from a diverticulitis in the corresponding bowel wall. (3) With sudden or gradual torsion there may

result a **detachment** of the appendix. It may remain free in the peritoneal cavity or surrounded by omental adhesions. These foreign bodies may vary in size from a pea to a hen's egg. They are usually rounded and may appear fatty, fibrocartilaginous, or even calcified. (4) **Adhesions** may be formed to the parietes or to a neighboring viscus. There is then the danger of an intestinal obstruction.

Clinical Features

With torsion or inflammation, abdominal pain is the only constant symptom. The pain is necessarily limited to the seat of the torsion, and may even be referred to the right side of the abdomen when the torsion is actually in the sigmoid colon. There is usually some tenderness and rigidity. Nausea and vomiting may occur. To quote Eliason et al: "The effort to make a diagnosis preoperatively is a matter of academic interest. It is true that one may often suspect the diagnosis, but it is impossible to be certain. It is sufficient to make the diagnosis of an acute surgical abdomen and to localize the pathology."

The treatment of a primarily diseased epiploic appendix is resection. The results are usually good.

Case Report

The patient was a plump woman, age 34. She was first seen on October 16th, 1945. She had had "odd pains" in the left lower quadrant commencing three days before. These had become constant in the last twenty-four hours necessitating her remaining in bed. The pain was so severe that it had kept her awake the previous night. There was no nausea or vomiting and her appetite remained good. In fact there were no other symptoms except for a slight increase in frequency.

She was lying in bed with her left leg drawn up. Extension increased the pain. There was tenderness in the left lower quadrant, also rectal tenderness. There was no rigidity. Her temperature was 99°, pulse 88. Further examination, including P.V. and urinalysis, was negative.

At operation two appendices epiploicae involving the terminal three inches of the descending colon were acutely inflamed. There were no adhesions. The appendices were excised and the wound closed. Convalescence was uneventful. Later section of the appendices revealed hemorrhagic areas.

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Magic and Medicine

J. C. Hossack, M.D., M.D.C.M.

Assistant Professor of Medicine, University of Manitoba

Coins are placed on the dead man's eyes and when he is carried forth it is feet foremost. At the church, bells are tolled and the procession moves forward with lights burning. So do the living seek to protect themselves from the dead by practices immemorially old. To our forefathers death gave no stay to malevolence. A wish was no less potent because it was looked and not spoken, and so the dead man's eyes must be shut and no backward glance permitted, for that last longing, lingering look behind may carry evil. Nor does encoffinement end the danger for the presence of a corpse will attract demons who must be driven away by holy noises—pagan tom-toms or Christian bells—and kept away by burning lights—torches, tapers, or auto head-lamps.

Universal in time and place is this fear of the dead. To uncivilized peoples of every age and clime few things are more potently pathogenic than are disembodied spirits. Supremely hurtful are the souls of virgins, or still-born children and of women who have died in labour. Most baneful of all are the ghosts of suicides. These can find no peace but must wander earthbound, stealing forth by night to torment the innocent and, by day, lying restlessly asleep in their tombs. The peasants of a dozen countries will tell you that only when these are pinned to the earth by a stake of yew driven through the heart, only then will the living be safe from the living-dead. Fear of the dead is thus sometimes greater than the fear of death.

It is scarcely too much to say that civilization is built on a tomb. Man became man when he realized the fact of death and civilization began with his first efforts to postpone it and, if possible, to avert, this end. The arts of the carpenter, the architect, the builder, the mason, the writer, the poet, the artist, the sculptor were invented, and first applied, in the interest of the dead, for the protection of their bodies and the perpetuation of their names. To pluck the sting from death and to rob the grave of its victory—these have been, since the beginning of time, and still are, the prime objects of man's life. These are the incentives that gave birth to, and have developed, the arts, sciences, literatures and cultures of modern man; and he is inspired by them still.

In the beginning when the fact of death first stunned his dawning consciousness, man found it hard to understand. He saw his friend or his enemy alert, vocative, helpful or menacing, and then, quickly or slowly, he saw the redness drain from the cheeks, the arms fall limp, the eyes

unshut but unseeing, the mouth open but silent. The transformation was so dramatic, so complete, that one would have marvelled had the watcher not been filled with awe, fear and perplexity. Here was a phenomenon which he had seen repeated time and again, yet what did it mean? Could he solve its mystery? He had other problems, too, although this was by far the most serious one, and for their general solution he devised a simple system of philosophy—the system which we call magic. In the earliest stages of his evolution he could conceive of nothing greater than himself and so, in the beginning at least, death was due to human agency even when no man's hand had been seen to touch the victim. Later on, when he had evolved his gods, he blamed them also. But the history of every primitive people tells us that magic and wizards long antedated the gods and the story of modern man reveals that the ancient belief still lives. The mystery of disease and death is not yet completely solved; no wonder then that the ancient solution was long the accepted one and has not yet been completely abandoned, though now it appears in a disguised form. It will therefore not be unprofitable to consider the influence of magic on medical practice both professional and lay.

First of all we must realize that it is no paradox to call magic a system of philosophy. In the words of McKenzie (*The Infancy of Medicine*), "Magic is in reality a system of philosophy; the most ancient, the most venerable, and popular of all, indeed. It is the cradle from which all other systems have sprung and it is the grave to which, in their senility and decay, they all decline. The savages in virgin woods, the priest-physicians of Egypt and Greece, the philosophers in the porches of Athens, the pharmacists of Araby, the astrologers of Chaldea, and, last but not least, medical men until the eighteenth century as well as the common people of every age and clime, one and all went to their daily tasks along the broad road of magic."

Magic is logical if we are prepared to accept its laws. The basis of these is essentially that whatever a man naturally imagines to be, is. According to the first law, like not only produces like but is like. The sailor whistling for a wind produces a sound resembling that caused by the wind passing through the shrouds. The wind itself is expected to follow, thus like produces like. As we shall see later an effigy becomes identical with its original, thus like becomes like. This is the law of homeopathic or mimetic magic.

The second law enunciates as a fact that things which have at any time been in contact with each other continue to act upon each other even after the physical contact has been broken. This is the law of contagious or telepathic magic. By these laws early man and his descendants for millennia conceived themselves and their universe to be governed. There seems to have been no single or isolated region in which these beliefs were born. Peoples far remote in time and place held, and hold, the same ideas; followed and follow the same practices. It would appear, then, that these beliefs are instinctive.

Both forms of magic (homeopathic and telepathic) were important in ancient etiology, pathology and treatment. The principal etiological agents were divine displeasure, possession by demons and wizardry. Epidemics always, and individual illnesses sometimes, were attributed to the anger of a god. Thus we have the Homeric story about the terrible revenge of Apollo upon the Greeks before Troy. Then there is the record in the Book of Samuel of the plague of emerods that "fell upon them of Ashdod and the coasts thereof." The Assyrian who "swept down like a wolf on the fold" lost of his cohorts an hundred fourscore and five thousand who were slain by a Jehovah-sent pestilence. As the moment we shall neglect the association of magic with epidemics, and confine what follows to the chronic ailments which, for the most part, were attributed to wizards.

A common way to afflict an enemy with disease or to bring about his death was to make an effigy, give it the victim's name and do things to it which, if done to the original, would cause suffering or even loss of life. This was the application of homeopathic or mimetic magic. The wish identified image and victim. The mimicry of torture produced the pains of torture. It was not essential for the effigy to be a recognizable image, for the potency of the wish overcame all technical deficiencies. The effigy was made of whatever materials came readiest to hand but the curse was made much more powerful if some part of the victim could be incorporated — a tooth, for example, or his hair or nail-parings. Thus was telepathic magic added to homeopathic magic. The practice of using effigies was universal and is still far from rare in some backward parts of the world. In the Scotch Highlands clay was used; in the Malay States, wax; in North America, wood. When the figure had been formed and identified it was solemnly cursed, the desired effect being mimicked. Thus the Highlander would set his handiwork in the bed of a stream with the wish that as the image wasted away, so would his victim. The Malayan uses wax and holds it before a fire so that his victim may be consumed

by the heat of fever. The American Indian shapes a little doll of wood and then pierces it with thorns in its limbs and body so that the one upon whom he seeks to vent his hate will endure the agonies he imitates.

Sometimes not an individual but a tribe was the object of the spell. Then one of the practices employed was that mentioned in the Book of Exodus, "And they took ashes of the furnace and Moses sprinkled it up toward heaven and it became a boil breaking forth into blains upon man and upon beast." This procedure, followed by Moses 3,000 years ago, and even then ancient, is still used by the Australian Blackfellows. This is the practice called "sendings," and it includes the introduction of stones into the bodies of enemies. The fact that a curse has been uttered is made evident by the pain and the subsequent passage of blood or gravel. Thus does the aborigine explain the presence of stones; they have been conjured into the body by wizards for obviously in no other way could such objects pass the barrier of the unbroken skin.

By virtue of the second law of magic — that objects once in union remain in union — one's person is extended in many ways and his vulnerability correspondingly increased. Thus the clipped hair, the nail-parings and the fallen teeth are, according to this law, tangible portions of the body still in magical attachment. They are keys which directly open the door of the personality to the wizard's attack. The clothing and personal intimate belongings are also by the same token sympathetically bound to their former wearers who can be reached through them. Such has been the belief of every wizard from the prehistoric magician to the clairvoyant of today. Less tangible but no less influential are the foot-prints, the name, the picture and the shadow. By placing sharp flints in the foot-prints of his enemy the Blackfellow seeks to lame him. Parents are careful to give their children "lucky" names. Robert III of Scotland changed his name from John to change his luck, a practice not unknown to those who are, or hope to be, the darlings of Hollywood. The bitter curse of Margaret (widowed Queen of Henry VI) which she hurled against Gloster, fell completely upon herself when that cunning Duke cried "Margaret" just as she had "Richard" upon her lips. Explorers everywhere find it difficult to coax natives to have their pictures taken because to the savage the picture is a portion of himself through which he can be injured. Even today in India the Brahmin upon who has fallen the shadow of one of the lower caste hastens to wash himself clean of the pollution. Among the native tribes of New South Wales it is grounds for divorce if a man's shadow falls upon his mother-in-law! In Roman

shadows are incorporated into buildings to give them strength. Those whose shadows are thus stolen from them soon die. Through these additions to, and outworks of, his personality, man becomes terribly vulnerable to his ill-wishers. He can be robbed of his ease and of his life in a dozen ways.

We may smile at the credulity of those who lived in the fear of magic. "How ridiculous!" we exclaim, "to think that any harm could be wrought by this mumbo-jumbo. Surely everyone must have learned by repeated failures that magic has no potency." But there were no failures! The magic did work! That is why 6,000 years have not succeeded in making the practice obsolete. You see, the wizard did not expect either an immediate or an exact fulfillment of his curse. But in tuberculosis-ridden Scotland wasting was far from rare. There could be few jungle dwellers immune to the prevalent fevers. The ill-protected, nomadic brave was constantly in danger of wounds and other pain-producing ailments. And when these happenings did occur, even though long after the uttering of the spell, the wizard saw the culmination of a process initiated by himself.

Man was therefore well satisfied that his magic was potent. So potent was it indeed that he went in daily terror of wizards who tried to take, and in the end always succeeded in taking, from him his life. To extend his life was his chiefest interest and, as by magic he could lose it, so by magic did he seek to save it. Then as now prevention was preferred to cure. Prophylactic treatment, therefore, formed a large part of primitive therapy. Man sought to prevent death by giving himself an extra quantity of life so that with this excess he could afford to lose some and still be out of danger of losing all.

Primitive man recognized a number of objects as life-givers. Chief of these was blood. He saw the glowing cheeks of the lively warrior turn white as the blood poured forth carrying life with it. Blood and life, he said, are the same. In the words of Moses "The blood thereof is the life thereof." Now the principal characteristic of blood is its colour and according to the law of homeopathic magic things that resemble each other possess the same properties. All red things were thus endowed with the life-giving property of blood. Therefore when life was likely to be endangered the savage would give himself an extra quantity of life by painting himself red and by wearing red amulets. Further he used the pigment to alter his appearance, partly in order to increase the terror of his enemies and partly so to disguise himself that a demon searching for him might pass him by. The red tunics recently worn by soldiers were not worn for the

purpose of concealing the effusion of blood but as a blood substitute. The ancient belief still persists in the lay preference for red flannel, red tonics and red pills. Lipstick and rouge also have here their origin, for by their use the most anaemic and wan can duplicate the rosy cheeks and ruby lips of health; and when so adorned women actually feel better!

Yellow objects also enjoyed magical potency, for yellow is the colour of the sun and the sun is a life-giver par excellence. The discovery of gold was therefore epoch-making, for it brought the very sun itself into the hands of man. We have no record of the occasion but it is not difficult to imagine the circumstances surrounding this eventful discovery. Someone with his mind on other things had his attention caught by glittering particles such as he had never seen before. Yellow, bright, sparkling—they were like fragments of the sun. The sun was a god. This, too, must be divine. Could it be—and one can see his hesitation as he formulated the tremendous thought—could it be the seed of the god? With natural concern he gathered this quintessence of life and laid it before his king. Search was made for more and more was found. Then closer scrutiny and larger experience revealed that it was malleable. It could be made into a ring and so was magic added to magic for the ring is unending just as man wished his life to be. Moreover it could be fabricated into other life-giving forms. For example upon the ring might be engraved a cowrie shell, which from its imagined similitude to the form of a woman was, like woman, life-giving. Further there could be set in it a ruby the redness of which gave it the properties of blood. Thus were combined the magic of the ring, of the cowrie shell, of woman, of blood, and so was increased by many times the magic native to the gold.

It was this magical property of gold that made it so much sought after. Early exploration was motivated by a search for gold. All the most ancient ruins have been discovered near places where gold has been found. The value of the metal as a giver of life gave it its commercial importance and made it the metal of choice for ornament making.

Ornaments were originally worn for their magical properties. Gold was life-giving and there was also magic in the design. Further, it was possible to use the ornament as a container for some object held to be of great virtue. A modern example of the use of an ornament as an amulet is a maiden placing her photo in a locket, golden and heart-shaped, along with a lock of her hair and hanging it around her sweetheart's neck with a prayer for his safe return. The gold gives life, the heart is her heart, her photo and her hair

are the same as her personal presence, and the wish is tantamount to its fulfillment. Even today superstitious people place great faith in "lucky pieces," which range all the way from medals and coins to fragments of cloth, wood and stone, pieces of animals and so on. The design, the words they bear, the circumstances under which they were acquired, or the associations of these objects appeal to the wearer as being protective and, in general, "lucky." Thus the negro clutches his hare's foot with the same faith that the medieval noble held on to his opal.

A special virtue resides in charms. In essence these are wishes. "Goodbye" means "God be with you." Writing the wish or the charm made it more lasting. Sacred words worn upon the person, bound upon the arms or the forehead, or attached to the door according to the Jewish custom and in a measure like the practice of the Arabs, was the same as having about one the actual presence of the deity; for the written word was magically the same as the spoken word, and the spoken word was part of the one who spoke. The sanctity of swearing upon the Bible lies in the fact that the oath-taker, according to the ancient belief, touches his Creator as he swears. Enclosing a charm within, or writing it upon, an amulet was therefore an important method of prophylaxis.

Prophylaxis, however, was not always successful and then treatment had to be direct and specific. Failure of cure was attributed to extraordinarily potent magic and no blame was attached to the therapist, especially when there was reason to believe that the sufferer was the victim of divine displeasure. If then the appropriate priest could not help, there was no help. Demons were somewhat less troublesome. Possession by demons was widely and for long accepted as a definite cause of illness. Treatment was aimed at making the evil spirit's habitat so uncomfortable that he was glad to vacate. Thus the poor madman was beaten and scourged. Disgusting remedies were forced down his throat. One of these included vile-tasting and evil-smelling plants such as assafoetida and valerian to which was added juice of herrings, the whole dissolved in sour beer and drunk out of the church bell. The exorcist robed himself in garments of mystical significance and often disguised himself with a mask so that between the sanctity of his dress and the concealment of his features the demon would avoid and fail to recognize his attacker. The cure being as terrible as the disease no one who had once been possessed was anxious to repeat the experience and so efforts were made to prevent recurrence. Change of identity was therefore attempted. One could merely change his name as does the modern transgressor of the laws of his country, but a much more effective practice

was death and re-birth. This was done symbolically by having one's friends push him into a small hole or cave and then dragging him forth again.

Another way to be rid of an affliction was to give it to some other person, to an animal or even to a plant. This is called "transference." Sir Walter Scott was wrapped in the hide of a freshly-killed sheep in the hope that his lameness would pass into the skin. In certain rural districts in England a consumptive was made to sleep in a sheepfold so that the sheep might take away the disease. In Rome colic was treated by placing a live duck against the belly of the sufferer whereupon the pain passed into the duck. By killing the duck the pain also was killed. In Rome, also, the victim of fever had his nail parings stuck upon the door of a neighbor who was expected, in an excess of neighborliness, to take the fever and cure the patient.

A popular object upon which to unload a disease was a corpse, and among corpses the favourites were suicides and children, especially still-born children. A recognized cure for goitre was to touch the neck of the patient with the dead hand of one of these. The hand of an executed criminal was specific for wens and we are told that sufferers used to gather about the gallows at every execution in order to avail themselves of treatment. When Don Carlos the son of Philip II of Spain was ill he was laid in the same bed as a corpse for his healing. There still persists a belief in the efficacy of transference in the case of venereal infection and male sufferers have been known even recently to deliberately seek intercourse with virgins for the purpose of ridding themselves of their ailment. Less often one hears of an infected woman seducing a boy for the same reason.

"It is constantly received and avouched," says Bacon, "that the anointing of the weapon that maketh the wound will heal the wound itself. In this experiment, upon the relation of men of credit (though myself as yet am not fully inclined to believe it), you shall note the points following, first, the ointment wherewith this is done is made of divers ingredients, whereof the strangest and hardest to come by are the moss upon the skull of a dead man unburied, and the fats of a boar and a bear killed in the act of generation." The difficulty of obtaining such an unguent prevented the incredulous from saying that the remote treatment of wounds was ineffectual. By the law of contact magic, of course, wound and weapon became identical and by the law of homeopathic magic any object which was like the weapon could, by wishing, become identical with the weapon. Thus if the weapon which had been used could not be identified, it was sufficient to anoint any similar arm and the magic would work

Frazer tells us that in Suffolk when a man runs a thorn into his finger he carefully greases the thorn after its extraction so as to prevent suppurating.

From Greek times on it has been the practice to take obstinate ailments to temples for direct treatment by the gods to whom the temples were dedicated. The tales told about the miracles there accomplished stagger the imagination. Cleo, for example, was relieved of a pregnancy which had lasted for five years. When a cure had been made the delighted patient usually left, engraved in stone, the history of the case and a representation of the organ cured, or the appliance now no longer useful. These representations served a double purpose. First they were advertisements for the god and second they were a means of leaving the ailing part under the god's eye, for the picture of a stomach was the same as the stomach itself and recurrence of the trouble was unlikely to occur when the organ was reposing in the atmosphere of healing.

Ancient materia medica included for the most part remedies with magical significance. Thus in Egypt a sovereign remedy for indigestion was pig's teeth. That was because the Egyptian could not conceive of a dyspeptic pig. That part of the animal which came in closest contact with the raw food was of course the teeth. To give the patient the pig's teeth was the same as giving him the digestive prowess of the animal. In other countries bear's grease was used as a remedy for baldness, snake oil against rheumatism, syrup of foxes' lungs against asthma. All of these remedies are still in use by laymen to whom they seem to be eminently natural medicines. The spider was used as a remedy for ague because no one had ever seen a spider shaken in a rigor. It was caught, put in a little box and worn upon the person. This was the Roman practice. In Ireland the spider was swallowed. The spider and its web, made into pills, were used in India and, strange as it may seem, the remedy was found to be effective by Sir Thomas Watson in 1867; the reason for this being given in 1882 when the Spaniard Oliva found in the webs a febrifuge substance which behaved somewhat like

quinine. Thus, in at least one instance, has the new magic of the chemist endorsed the old magic of the wizard.

The search for means to rid him of disease has led man to employ every natural object as a remedy. In some cases, as for example opium, cinchona and castor oil, rational remedies were employed although very often their efficacy was attributed to them being extraordinarily magical. Often the odour or taste of a medicine gave it potency and the very common use of disgusting substances such as excreta was based upon the belief that the spirit of the disease would prefer to inhabit a person more particular in what he swallowed. An ancient remedy for displacements of the uterus was disgusting potions, which drove the womb down to the pelvis together with pleasantly smelling fumigations which charmed and allured the wandering organ back to its normal site. From time immemorial search had been made for the universal remedy. There were various contenders for acceptance, chief of which was one that included flesh of vipers. The name given to this universal specific was "theriac." It was an official remedy until the middle of the eighteenth century when, on the suggestion of Heberden, it was dropped from the pharmacopoeia. Heberden's motion was carried by a single vote! To complete the disgrace of theriac it now is sold, minus the viper's flesh, as — treacle!

Belief in magic still lives. Druggists still sell medicines whose chief virtue lies in the fact that they are made by widows or from the formulas learned from Indian medicine-men. The mumbo-jumbo of the chiropractor is in lineal descent from the mumbo-jumbo of the witch doctor. Trusting people invoke the aid of fortune-tellers, astrologers, faith healers, cultists and the other present day representatives of the ancient magician. Otherwise intelligent people do not hesitate to follow the advice of men and women palpably ignorant of everything except the profundity of human credulity. Time has changed our race in many ways but it has not rid it of the wishful thinking that fills man's heart and is the basis of magic.

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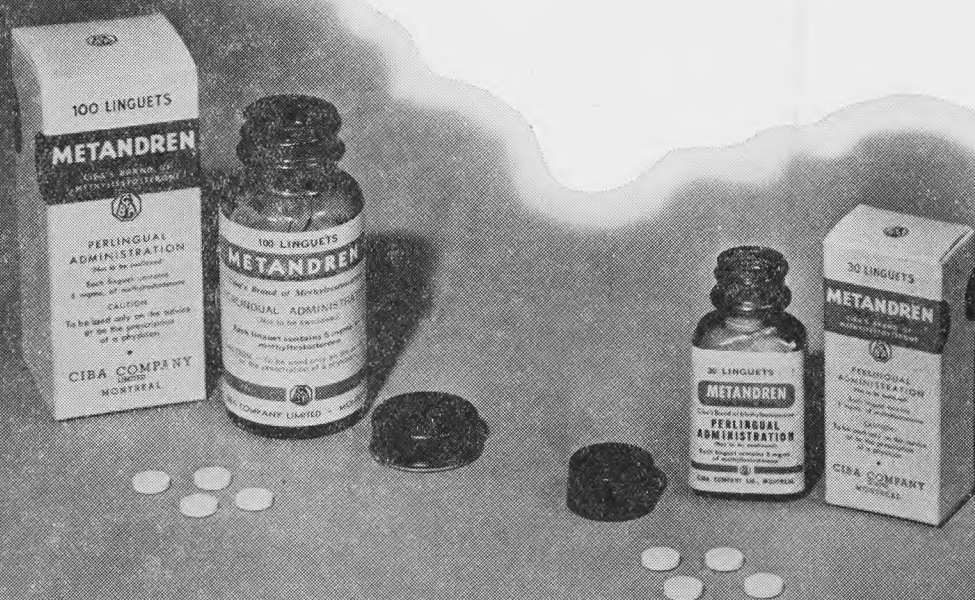
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MONTREAL

Anesthetic Section

P. C. Lund, M.D., Anaesthetist, Deer Lodge Hospital

Section of Anesthesiology

Abstract

The Use of Curare in Anesthesia — R. T. Knight

Minnesota Med. 27: 667 - 668, Aug., 1944.

Curare has been used in the physiological laboratories for a great many years as an agent which paralyzes muscle. Its action is at the myoneural junction (interrupting nerve impulses at this junction by neutralizing the acetylcholine reaction which is the fundamental neuromuscular stimulation mechanism). So far as has yet been found, it has no other effect upon the nervous system. Like all drugs which anesthetists use, curare has a progressive effect upon different parts of the organism; one group of muscles after another being affected. The muscles of the throat are affected, just impairing the swallowing reflex. The conscious animal becomes unable to swallow saliva, followed by inability to cough and extrude the saliva which has entered the larynx and trachea. The muscles of the extremities then become weakened and paralyzed so that the animal is unable to walk and falls down. The muscles of the trunk then lose their tone. Costal breathing ceases and the abdominal muscles become flaccid. The last effect is then upon the diaphragm, and when this becomes paralyzed, respiration of course ceases and death ensues. Each one of these effects takes place in progression as the dose is increased until it reaches the lethal dose.

The effects of Curare on the anesthetized patient are briefly as follows: When general anesthesia is very light and reflexes of the pharynx and larynx are in evidence with a tendency to laryngeal and laryngeal spasm and partial respiratory obstruction, one of the first results of Curare noticed is the release of this spasm. The next very evident effect is the relaxation of the abdominal muscles. This relaxation compares very favorably with the relaxation obtained by spinal anesthesia. The abdominal muscles are in the same group with the intercostal muscles being supplied by the same nerves and being susceptible to the same dosage of any general anesthetic are of course also susceptible to the same dose of Curare. Thus when complete abdominal relaxation is obtained, the intercostal muscles are at the same time paralyzed and breathing is carried on by the diaphragm alone.

It is very important to realize that when Curare is employed, the same thing takes place, "i.e., Intercostal muscles cease to move when the abdomen is well relaxed." The next increase in

dosage also paralyzes the diaphragm, and respiration ceases. The dose must be planned and administered so that this last event does not happen. However, if the dose is miscalculated the patient can be well oxygenated by manual compression of the breathing bag. Dr. Knight points out that Curare should never be given unless the anesthetist knows that the mask can be fitted perfectly and the jaw and tongue can be well supported, so that this type of artificial respiration can easily be carried on. The alternative of this is the use of the endotracheal tube. One feels perfectly assured of being able to carry a patient satisfactorily through a period of paralysis of the diaphragm if good means of artificial respiration are present. Prostigmine is the specific antidote.

The average intravenous dose of Curare ranges from 60 to 100 milligrams according to the size and vigor of the patient and the depth of anesthesia when the Curare is administered. The full effect takes place in from 40 to 60 seconds. In the early cases in their series they tried to estimate the dose needed and then gave the whole amount in one dose; employing this technique, they experienced three arrests of respiration. Latterly they have employed an intermittent technique administering 40 - 60 milligrams and then awaiting developments; if in a minimum period of one minute relaxation is insufficient, 20 milligrams are added at a time until relaxation is complete.

Dr. Knight also points out that the action of the drug is of rather short duration and another dose must be administered in from twenty minutes to an hour and a half. The clever anesthetist is able to keep the general anesthesia very light so as to actually have need for additional Curare. It is rather easy to allow the administration of the general anesthetic to proceed so that sufficient relaxation is maintained without more Curare. This is what we should avoid as the patient recovers from Curare without the slightest depression. Our object is to avoid the depression of deep general anesthesia. Although the duration of the Curare effect is usually as stated from twenty to ninety minutes, it should never be repeated according to lapse of time, but only as the signs of receding effect appear. Then the second and ensuing doses should be smaller than the first. In conclusion, the author states "It seems that Curare bids fair to replace not only a great deal of deep ether anesthesia but a great deal of spinal anesthesia as well."

P. C. Lund, M.D.

Abstract

Abdominal Relaxation in General Anesthesia

M. Kleinman

Anesth. and Analg. 23:196 - 201, Sept. 1944.

The author points out that in the performance of an operation the safety and comfort of the patient is of primary importance; and that there is some difference of opinion between the surgeon and anesthetist as to what constitutes good anesthesia.

In general, it may be said that it is the function of the anesthetist to provide for the surgeon the maximum abdominal relaxation compatible with the patient's safety. Unfortunately complete abdominal relaxation depends on many factors over which the anesthetist may have no control. General anesthesia acts first on the higher brain centres causing unconsciousness and abolition of pain sensations. This stage is not sufficiently deep for abdominal surgery. It is necessary to eliminate spinal reflexes in order to prevent reflex muscular contractions during abdominal operations. Spinal reflexes disappear beginning at the lower end of the spinal column and extending upward toward the brain. This explains the necessity for deeper anesthesia in the upper than in the lower abdomen. In order to obtain muscular flaccidity in operations on the upper abdomen, it is necessary for the anesthetist to eliminate reflexes as high as the second dorsal vertebra. This is the highest level reached by nerve fibers supplying the abdominal muscles. When the anesthesia extends to this level, all muscular reflex spasm of the abdominal muscles is eliminated. Muscular flaccidity also depends on the muscular tone. Therefore, muscular flaccidity is more readily obtained in old or weak patients. In order to abolish muscle tone it is necessary not only to eliminate reflex muscle spasm but also to impregnate the muscle fibers with the anesthetic agent. This can be accomplished by induction of anesthesia at least ten minutes before the operation is begun. In this case choice of anesthetic agent is of primary importance. Chloroform ranks first among agents affording a high degree of muscular flaccidity. However, it is also the most dangerous anesthetic agent. Ether ranks second in producing the same effect. Unfortunately, ether as well as chloroform when administered in doses sufficient to obtain complete muscular relaxation, may precipitate vascular collapse. In both cases the margin of safety between complete muscular relaxation and vascular collapse is relatively small. Cyclopropane affords good relaxation by suppression of reflex muscular spasm through the spinal cord and by diminishing respiratory movement due to a depressive effect upon the respiratory system. However, even in deep anesthesia

this agent does not diminish muscular tone. Anesthetists and surgeons who prefer cyclopropane anesthesia should understand that this agent will not provide the same degree of muscular flaccidity afforded by chloroform or ether.

Additional factors which play a role in muscular flaccidity are anoxia and carbon dioxide in the circulation. Both of these factors act as stimuli for muscular tone. These two factors usually act together and eliminate the possibility of satisfactory muscular relaxation even in deep anesthesia.

Nitrous oxide and ethylene are weak anesthetic agents and do not afford muscular flaccidity. Frequently good muscular relaxation in conjunction with general anesthesia may be obtained by injection of 1 percent procaine in the abdominal muscles.

Visceral stillness is also necessary to afford satisfactory abdominal relaxation for surgical procedures. To some extent visceral stillness is dependent upon muscular flaccidity. However, other factors enter in, of which the most important is the patient's respiration, which must be maintained as close to normal as possible. This can readily be carried out with cyclopropane which is a depressor of the respiratory center. Ether anesthesia, however, introduces another factor. If the anesthesia is sufficiently deep to obtain good muscular flaccidity the intercostal muscles are also paralyzed and respiratory movements are completely taken over by the diaphragm. When this occurs the movement of the diaphragm exerts pressure on the abdominal viscera with resulting protrusion through the incision. In other words, "visceral stillness" is not present.

Visceral stillness with ether anesthesia may be obtained by (1) administration of light anesthesia at the sacrifice of some degree of muscular flaccidity, (2) administration of very deep anesthesia so that the movement of the diaphragm is also diminished, or preferably (3) maintenance of controlled respiration in the patient.

In closed system anesthesia insufficient absorption of carbon dioxide will produce a deep abdominal type of respiration with consequent protrusion of viscera through the incision. The abdominal type of respiration is normal in children and obese adults and consequently, it is difficult to obtain satisfactory relaxation in these patients. The most frequent and the most important cause of failure in obtaining visceral stillness is respiratory obstruction. Respiratory obstruction results in forced respiratory effort with consequent contraction of both the respiratory and abdominal muscles. There is also an increase in intrathoracic pressure which acts upon the diaphragm and thereby increases the intra-abdominal pressure. In addition, with respiratory obstruction

tion, there is poor exchange of oxygen and carbon-dioxide which causes an increase in muscle tone.

Obviously, then, abdominal relaxation is impossible in the presence of respiratory obstruction, of which the simplest cause is the posterior relaxation of the patient's tongue. Other causes of respiratory obstruction are increased secretions, aspiration of foreign bodies and incorrect position of the head. The most important cause of respiratory obstruction, however, is laryngospasm, which occurs frequently and is difficult to combat. The most efficacious procedure in preventing or overcoming laryngospasm is tracheal intubation. This affords good oxygenation, efficient elimination of carbon dioxide, visceral stillness, improved control of anesthesia and ease of artificial respiration. (Many authors feel that tracheal intubation should be carried out in every major abdominal procedure under general anesthesia, particularly when cyclopropane is used.)

Bronchospasm is another cause of respiratory obstruction occurring particularly in asthmatic or allergic patients. Celiac reflexes, caused by stimulation of the celiac plexus in sympathotonic patients, is manifested by a stiff abdomen and protrusion of abdominal viscera. This results in complete absence of abdominal relaxation which cannot then be achieved even with dangerously deep anesthesia. Celiac reflex may yield to the injection of physostigmine. This reflex may be avoided by adequate premedication of these sympathotonic patients and use of cyclopropane rather than ether in upper abdominal operations.

When visceral volume is increased by marked meteorism there is interference with operative technique even in the presence of good abdominal relaxation. Protrusion of viscera occurs; thus general anesthesia is frequently unsatisfactory for intestinal obstruction. The same difficulty is some-

times encountered in operations for post-operative abdominal evisceration.

Increased visceral volume of less degree, due to presence of intraperitoneal fat, may occur in obese patients, when closure of the abdominal wall becomes difficult even when good relaxation is present. This condition, added labored respiration and abdominal type of breathing characteristic of the obese, makes general anesthesia difficult to administer to this class of patient. Cyclopropane anesthesia is usually accompanied by dilatation of the intestinal loops, complicating abdominal surgery.

Visceral incarceration frequently occurs during abdominal operations utilizing small incisions. This condition is not the result of failure to obtain complete abdominal relaxation. It is merely a physical phenomenon, due to the difficulty in returning the visceral contents into the abdomen through a small incision.

Basal narcosis markedly diminishes reflexes, thus favoring muscular flaccidity. It also depresses respiration with consequent visceral stillness. It is for this reason that good abdominal relaxation is usually obtained when basal narcosis has been used.

The personal factor is an unknown variable frequently encountered. Patients who appear to be good operative risks may go into shock on the operating table. Such individuals, though apparently normal, are unable to carry the extra burden superimposed by the anesthesia and strain of the operation. In such cases anesthesia must be administered cautiously even at the sacrifice of complete abdominal relaxation. Anesthesia must be individualized to meet the requirements of both the patient and the surgeon.

P. C. Lund.

Obituary

Dr. Lewis James Carter

Dr. Lewis James Carter died February 19, 1946, at his residence in Brandon. Born in Huron County, Ontario, January 25, 1874, he moved with his mother to Winnipeg at an early age. After graduating in Arts from Wesley College in 1899, he entered Manitoba Medical College and received his M.D.C.M. degree in 1903. For some years he practised at Boissevain, then moved to Brandon and became a member of the Bigelow Clinic at its foundation in 1915.

For a quarter of a century he specialized in the field of radiology. He was a Fellow of the

American College of Physicians, a member of the Radiological Society of North America, Fellow of the American College of Radiology, and held a certificate in Diagnostic and Therapeutic Radiology from the Royal College of Physicians and Surgeons of Canada.

Dr. Carter was a member of the First United Church of Brandon. In his college days he played football, and later was a member of the Brandon Golf and Country Club, and an ardent hunter and fisherman.

He is survived by his wife and one son, Lieut.-Commander A. Bruce Carter, R.C.N.V.R., of Winnipeg, and two grandchildren.



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Clinical Luncheon Reports

St. Boniface Hospital

Localised Abscess in Spinal Canal

A. T. Gowron, M.D.

A farmer's wife of 63 was seen on January 18, complaining of severe backache of two days' duration. The onset had been sudden and there was no history of previous illness or injury. Physical examination, done under unsatisfactory conditions, showed great tenderness of the lower back, especially about the sacro-iliac joints. Because no hospital bed was available the tender area was infiltrated with novocaine and, as this gave much relief, she was sent to friends in the City. Two days later she reported by telephone that her back pain was much easier but that both legs were sore, and so weak that she could not stand or walk. The following day she was much easier but on the day following that (a week after the pain began) she was worse and was unable to void. She was sent to hospital for catheterisation only, because there was still no bed to be got. She was finally admitted to hospital on the 24th.

On admission she was very restless and moaned continuously and loudly. She did not pay much attention to questions but it was gathered that she had severe pain in the head, neck and back. She could neither void nor defecate. Temperature, pulse and respirations were normal. The back was very stiff. The blood pressure was 170/95 (it had previously been normal) but otherwise the cardiovascular system was normal. The abdomen was negative apart from a swelling due to the distended bladder. The pelvis was negative. Movements of the legs were weak and the jerks were sluggish. Babinski's sign was absent but Kernig's sign was present on both sides. Examination of the sensory system was unsatisfactory because of her lack of attention. A diagnosis of meningitis was made and she was given penicillin and sulphadiazine. Morphine was given for the pain. Her temperature rose to 103. The blood count showed 18,650 leucocytes, 88% polymorphs. There were 4,250,000 red cells and the haemoglobin was 93%. Urinalysis showed blood. Lumbar puncture was done and the fluid recovered was thick and purulent. The cells were nearly all polymorphs and there were many gram positive cocci. The Wasserman Reaction was negative.

The finding of what amounted to an abscess suggested that active disease might be present in the spine and this was X-rayed. The radiologist reported "There is marked narrowing of the lumbo-sacral interspace and lipping of some

of the lower lumbar bodies. The bones are slightly decalcified." Treatment was continued and for the next four days her condition remained unchanged with the temperature around 101° or 102° until January 29th when it fell to 100° and a day later to 99°.

On the 30th lumbar puncture was repeated. Nothing came through the needle and thick greyish pus was aspirated with a syringe. Penicillin—50,000 units—was injected. The laboratory reported a culture of staphylococcus albus. The diagnosis was changed from meningitis to intrathecal abscess. Two days later cisternal puncture was done. The fluid was slightly turbid and contained 111 cells, with polymorphs more numerous than lymphocytes. A culture of this fluid was sterile. Dr. H. Funk saw the patient on February 2nd. He reported: "Spine moderately rigid. Straight leg raising to 75°. Knee and ankle jerks sluggish but definitely present. Babinski negative. Lower lumbar spine and sacrum moderately tender. Movement in lower extremities present." In his opinion the lesion was a localised abscess causing pressure on the cauda equina. It was decided to operate.

Pentothal was used for anaesthesia. The fourth interspace and dura were exposed. The dura appeared to be thicker and more opaque than normal. It did not pulsate. There was no extradural pus. A needle was passed into the dura and strong suction was necessary to withdraw 5 cc. of thick pus. Fifty thousand units of penicillin were injected into the cavity. Temperature rose after operation to 103 and fell by crisis three days later. Since then it has been normal. The pus aspirated at operation gave a positive culture of staphylococcus albus. On February 9th haemoglobin was 63% and the red cells 3,300,000. There were 11,500 white cells, 75% polymorphs. Since then she has steadily improved. She has free and painless movements of her legs, no back ache and has full sphincter control.

This would appear to be an example of a localised abscess developing in the pia-arachnoid of the lowest part of the spinal canal. The symptoms were due to pressure upon the cauda equina and also to the sympathetic meningitis of which the cisternal puncture findings gave evidence. The early treatment with penicillin interrupted the progress of the abscess and gave time for a sealing-off process to develop. The removal of the pus at operation and the instilling of penicillin made complete recovery possible.

Preserving the health by too strict a regimen is a wearisome malady.—La Rochefoucauld.

St. Joseph's Hospital

Volvulus of the Sigmoid — Dr. B. Dyma

A woman of 56 was admitted to hospital complaining of constipation and colicky abdominal pains. She gave a history of having had her appendix and a pelvic tumour removed in 1934; a femoral hernia repaired in 1935; bilateral saphenous ligation in November, 1945, and acute phlebitis of the right leg in December, 1945. She was chronically constipated.

The present illness began suddenly on the evening of January 6th with severe colic which persisted. She refused to go to hospital so enemas were given at home and these were ineffectual. There was a great deal of distention and the pain was considerable. She was admitted to hospital on January 8th.

She was very emaciated and looked older than her age. Apart from the abdomen examination was essentially negative. The pulse rate was 108, the temperature 98° and the blood pressure was 150 - 90. The urine contained a trace of albumen. The abdomen was grossly distended and tympanitic. There was visible peristalsis. On the right side was a bulging and very tender mass. The whole lower abdomen was tender on palpation. Diagnosis was made of intestinal obstruction, but there was a question as to its cause. Volvulus was considered but the great emaciation and history of bowel irregularity suggested cancer. A flat plate confirmed the diagnosis of obstruction.

On January 8th in the evening she was operated upon under spinal anaesthesia. The sigmoid was found to be so enormously distended as to occupy the whole abdomen. The small intestine lay collapsed in the pelvis. The large bowel was purplish in colour. The torsion was relieved but there was no escape of flatus until a rectal tube was passed, after which the bowel became deflated. Careful examination then revealed no abdominal abnormality such as bands or diseased viscera. Recovery was uneventful.

Volvulus or torsion of the bowel usually occurs in the sigmoid where very often the bowel has an abnormally long mesentery, abnormally long loops, and an excessively narrow mesenteric attachment. When such a loop becomes filled with constipated stool the proximal limb may fall in front of the distal limb of the loop and the loop becomes twisted around its own mesenteric axis. Less often the torsion may occur in the small intestine and caecum.

The incidence of volvulus seems to vary in different countries. Thus in America it is the cause of about 8% of all intestinal obstructions. Pearlman, reporting from a clinic in Russia, found volvulus responsible for more than half the cases

of obstruction in a series of 200. Curschman, who made many autopsies upon Russians and Germans, found abnormally long mesenteries in 20% of the Russians but only 4% of the Germans. In the United States great stress is laid upon the uniformly present history of constipation. Bloodgood says that when the sigmoid is habitually distended with faeces its wall tends to become thickened and the bowel itself becomes longer and wider. The base of the mesentery thus becomes proportionally narrower as a state of contracting mesenteritis develops. This contraction approximates the proximal and distal portions of the sigmoid and twisting becomes more easy. Constipation and fermentation with gas formation distends the loop which then rises into the abdominal cavity. As the proximal sigmoid dilates it becomes more tense because of its fixation to the descending colon. Meanwhile the less fixed lower sigmoid and rectum rise and move to the left where resistance is least. The upper part of the sigmoid passes downward and to the right and volvulus results with clock-wise mesenteric twist up to 360°.

Volvulus of the sigmoid is a condition of later life and occurs four times as often in men as in women. According to Wargenstein this is because laxer walls and the roomier female pelvis make spontaneous untwisting more likely to occur.

Pain is usually early and severe but may be intermittent. Vomiting is late. The rapid, and soon enormous, meteorism is typical. Tenderness and rigidity are due to associated peritonitis. The X-ray film, however, gives the most conclusive help in diagnosis. The flat plate shows an enormously distended sigmoid occupying the right side of the abdomen and sometimes filling the whole cavity. The appearance after a barium enema is described as resembling the "Ace of Spades." This appearance is quite different from the ragged, uneven outline seen in cancer of the sigmoid. According to Griffin, complete volvulus of the sigmoid will permit the bowel to hold no more than 500 cc. of the enema. This was his result in 75% of his 25 cases. This, however, applies only to complete, not to partial, volvulus.

Among the conditions which must be thought of in differential diagnosis are: 1, mesenteric thrombosis; 2, acute pancreatitis; 3, peritonitis; 4, strangulated internal hernia; 5, stenosing cancer of the sigmoid; 6, spastic colitis with gaseous distention.

In uncomplicated cases the mortality is 50%; in cases requiring excision of gangrenous bowel it is 80%.

If symptoms are of short duration simple manual de-torsion may be successful. The patient is placed in the knee-chest position and barium and oil enema administered. In 20% of cases so

relieved the volvulus returned. When gangrene has developed excision is imperative. Griffin of Cook County Hospital advises exteriorization of the sigmoid loop and secondary resection later, as done by Mikulicz. Because of the danger of recurrence he recommends excision of all torsions of the sigmoid whether or not the bowel is viable. Exteriorization of the viable bowel gives the best prognosis.

Winnipeg General Hospital

Primary Thrombocytopenia — Dr. Robert Swan

A man of forty-one years, a railway worker, on an acetylene torch job had for some time, noticed frequent bruises especially on exposed areas. These caused him no concern until he began to experience repeated severe epistaxis in the spring of 1945. In August, a tooth extraction was complicated by excessive bleeding from the socket. Following a prolonged nosebleed in November, he came for examination on December 1st, at which time the only abnormalities discovered were bleeding time—15 minutes, Clot retraction—none, Hess capillary test—positive, Platelet count—none (Prothrombin time was 10 seconds and clotting time 7½ minutes—both normal). Hospitalization for further investigation was advised but refused.

The patient returned late in January and told of further severe nosebleeds but also complained of abdominal cramps, frequent bowel movements and blood in the stools. On January 20th there was marked anaemia (Rbc. 2.9, Hbg. 52%) and prolonged bleeding time (to 70 minutes) and prothrombin time, as well as the findings of two months before, but still no splenomegaly. Blood transfusion on February 17th raised the red cell count from 3.64 to 4.68, hemoglobin from 65% to 92% and was responsible for a platelet count of 15,000 per cu. mm.

The following **Classification of Purpuras** was suggested as a guide to diagnosis:

(1) With diminished blood platelets:

A—Primary (Essential or idiopathic) (Acute)
(Chronic)

B—Secondary to:

1. Infections (Subacute bacterial endocarditis, typhus, etc.)
2. Blood dyscrasias (Leukemia)
3. Allergy (drug and food)
4. Toxins (e.g., arsenicals and sulfonamides)
5. Diseases of liver.

(2) With normal platelet count:

1. Simple, senile, etc.
2. Anaphylactoid (Schonlein's, Henoch's)
3. Due to Vitamin deficiency (C and P)
4. Due to infection or toxin (e.g., meningococcemia).

All other types have been ruled out, and the eosinophil count of 30 per 1,000 sternal marrow cells tends to confirm a diagnosis of Primary Thrombocytopenic Purpura. Because of the chronic course, the repeated severe haemorrhage, and the danger of subdural hematoma it was felt splenectomy was indicated.

(Note: Splenectomy was performed on February 25th, 1,000 cc. of blood being given during and after the operation. During the first post-operative week the platelets varied in number from 15,000 to 25,000 and the bleeding time fell from 34 to 27 minutes. By the end of the second week bleeding time was 6½ minutes, and platelet count between 35,000 and 45,000. Hess test was still positive. Hemoglobin was 71% and rbc. 3.6 million.)

Removal of the Left Lobe of the Liver

Dr. P. H. Thorlakson

The patient was a woman of 62 years who for a year had had stress in the upper abdomen with loss of seventeen pounds and development of secondary anemia. Physical examination revealed a large mass in the upper left abdomen which was first thought to be spleen, but was later felt to be the left lobe of the liver. Barium series was negative except that the stomach appeared to be stretched out over the mass.

On December 10th, 1945, an exploratory laparotomy performed through a left rectus incision, revealed a tumor involving most of the left lobe of the liver pushing the right lobe over so that the gall bladder was in the right lower quadrant. There was no evidence of a primary growth in the gastro-intestinal tract or in the right lobe of the liver. The left lobe was freed from the diaphragm by incising coronary and falciform ligaments. There was no pedicle so liver incision appeared necessary if the tumor were to be excised. This was done between clamps after injecting 12 cc. of Topical Thrombin solution around the site of incision, and sewing over with ribbon catgut. There was no excessive bleeding. At no time were the hepatic artery or portal vein compressed.

The mass removed weighed 1,410 grams (the weight of the adult female liver) and consisted of a round fleshy tumor covered by a thin layer of liver tissue. Diagnosis was Myosarcoma, probably primary. Such tumors of liver are extremely rare—they may arise from aberrant muscle tissue or from the muscle in the blood vessel walls. Microscopically the mass was highly cellular with evidence of rapid growth. Prognosis is not good, recurrence is to be expected, but now, over two months following operation, the patient has no discomfort, eats well, has a normal blood picture and no evidence of metastases to the lungs.

Scleroderma—Dr. Arthur Birt

This is a condition of unknown etiology, characterized by induration of the skin in localized patches or diffuse areas, frequently associated with atrophy and pigmentation, and in the diffuse types with vasomotor disturbances, and, at times, myosclerosis and calcinosis. There are three types: (1) Localized (Morphea). (2) Diffuse. (3) Acrosclerosis.

Diffuse Scleroderma:

The first signs are stiffness, neuralgic or arthritic pains and paraesthesias. It starts as an infiltration or local oedema and spreads slowly. The skin becomes indurated, rigid, and bound down. Movement at joints is difficult, the face becomes mask-like. In the atrophic stage, the skin is thin, ulceration occurs over bony prominences, and pigmentation appears. Occasionally there is myosclerosis with extensive involvement of striated muscle (including respiratory muscles, heart, and muscles of deglutition). Sometimes there are calcareous deposits in the tissues (calcinosis).

Acrosclerosis combines Raynaud's phenomena with secondary scleroderma of the distal parts of the extremities and the face and neck. It is more frequently in women in adolescent or adult life. At first there is intermittent, arteriolar spasm with later development of sclerodactylia and sometimes facial sclerosis.

The patient is a man of thirty-one years, born in Manitoba, whose sickness began at six years, with painful soreness under the nails of his hands and feet. The skin became shiny and tight, the fingers and toes shrivelled. At sixteen years, ulcers of the legs appeared, healed, then recurred. When he was twenty-two, a lumbar sympathectomy was done in the hope of relieving the arteriolar spasm of the legs. The only effect was to reduce perspiration of the extremities and make the ulcers feel dull. During the past two years, it has become increasingly difficult to swallow solids and telangiectatic papules have appeared on the face.

Extensive laboratory investigation led to the following positive findings:

- (1) Blood sedimentation rate 30 mm. in 200 mm. tube in one hour.
- (2) Hbg. 78%.
- (3) B.M.R. 1%.
- (4) E.K.G.—T waves of poor quality in leads I and 2.
Inverted T 4.
Slight right axis deviation.
Interpretation—Myocardial change.
- (5) X-ray—Terminal phalanges appear to be absorbed, but no soft tissue calcification is shown.

Terminal portion of distal phalanx of right great toe is missing.

Fair amount of irregular periosteal thickening involving anterior margin of distal half of left fibula.

Barium passes through the oesophagus slower than usual but there is very little dilatation of the structure. No area of obstruction. No definite peristalsis.

Impression—The changes in the oesophagus are quite compatible with scleroderma but there are no characteristic deformities in the small intestine.

Treatment:

- (1) Penicillin ointment to leg ulcer.
- (2) Thyroid—alleged to increase the blood flow in cutaneous vessels.
- (3) Dihydrotachysterol (A.T. 10) — Several recent reports claim benefit from its use.
- (4) Protection against cold and trauma.
- (5) Prohibition of smoking.

Other suggested remedies include Pituitrin, Mecholyl, Prostigmine, and Papaverine.

An Unusual Case of Septic Temperature Following Abortion—Dr. Ross Mitchell

This woman, now thirty-six, was first seen in 1942, at which time she had been married a year without becoming pregnant. There was a history of a miscarriage over ten years before. Physical examination revealed no significant abnormality. It was decided to try the effect of thyroid.

About June, 1945, she was again seen, this time because of Menorrhagia. There was no enlargement of the uterus. Hemoglobin was 80%. On October 18th, her last menstrual period having lasted from September 16th to September 30th, a mass was felt extending 16 cm. above the symphysis. The cervix was not soft. A one-day flow occurred on October 27th. By November 7th the mass extended 2 cm. higher than three weeks before and there was a black discharge from the cervix. X-ray showed no evidence of a foetus.

Hemoglobin was 59%, rbc. 3.3 million. Iron and liver were given. Diagnosis was Fibromyoma. Three weeks later, massive haemorrhage was associated with passage of a 2 cm. foetus (6—8 weeks). Following this there began a temperature swing from 101—103° not affected by sulfadiazine, together with right-sided pain. Treatment was transfusion, penicillin and sulfonamides.

On January 13th the patient was again hospitalized. Hemoglobin was 57%, rbc. 3 million. Blood transfusions were given on January 16th and 17th and subtotal hysterectomy performed on January 25th. The specimen contained a large fibromyoma showing red degeneration and necrosis. Two days post-operatively temperature was 99°.

It was felt that the fibroid had probably been developing since May. The menorrhagia then complained of was no doubt due to a submucous growth. Degeneration with pain, temperature and chills was favored by pregnancy.

A Case of "Atypical Pneumonia"

Dr. J. D. Adamson

The course of a respiratory infection in a twenty-four year old male was reviewed through its three stages by means of a history summary on lantern slides.

January 17th, 1946—Cough began insidiously. Small quantity of thick sputum. Mild retrosternal rasp. Felt well—no constitutional symptoms—good appetite, continued work.

Diagnosis: **Tracheitis** (Bacterial or virus).

January 21st, 1946: Developed simple coryza and nasal obstruction. Other symptoms slightly abated, felt well.

Diagnosis: Spread of infection to **upper respiratory tract**.

January 23rd, 1946: Above symptoms gradually improved. 7 p.m., suddenly developed weakness, nausea, headache, and chilliness. Admitted to Hospital—T. 104°, P. 130, R. 20. Wbc. 16,250 (87% p.m.n., 36% young). Throat—Red, no exudate. Lungs—Rough breath sounds right axilla.

Diagnosis: Extension to **lung**—likely pneumococcal lobar pneumonia.

Treatment: None.

January 25th, 1946: A.M.—T. 100°, P. 100, R. 20. Feeling quite well except for slight weakness. No symptoms except slight cough and coryza. Lungs—Slight dullness and prolonged expiration over right hilum. P.M.—T. 98°, P. 76, R. 20. Wbc. 7,050 (46% p.m.n., 8% young). Blood sedimentation rate 28 mm. Sputum—Few gram positive cocci.

Culture—Staph. aureus. Sarcina. Pneumococcus type 23.

Chest Plate—Beginning infiltration of right hilum extending into lower lobe.

January 27th, 1946: Symptoms all cleared except slight cough.

January 29th, 1946: X-ray negative.

Conclusion: Primary bacterial invasion of trachea. Secondary spread to upper respiratory tract. Tertiary spread to lung parenchyma which lasted only a few hours.

Diagnosis: Pneumococcal Pneumonia (abortive).

Comment

(1) Most acute pneumococcal lobar pneumonia starts like this with primary infection in upper respiratory tract. On admission to hospital this case showed all the evidence of lobar pneumonia except pain.

(2) Many cases spontaneously abort as this did.

(3) Some older observers thought that this was the true course of pneumonia, and that gross consolidation was really a complication due to obstruction.

W. W. G.

Medical Happenings for April

Tuesday, 2—

Luncheon, Misericordia Hospital, 12:30 p.m.

Wednesday, 3—

Tumor Clinic, Winnipeg General Hospital, 9:00 a.m.

Thursday, 4—

Luncheon, Winnipeg General Hospital, 12:30 p.m.

Wednesday, 10—

Tumor Clinic, Winnipeg General Hospital, 9:00 a.m.

Wednesday, 10—

Meeting, Council, Winnipeg Medical Society, 12:30 p.m.

Thursday, 11—

Ward Rounds, Children's Hospital, 11:00 a.m.

Thursday, 11—

Luncheon, St. Boniface Hospital, 12:30 p.m.

Friday, 12—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

Tuesday, 16—

Luncheon, Grace Hospital, 12:30 p.m.

Tuesday, 16—

Luncheon, St. Joseph's Hospital, 12:30 p.m.

Wednesday, 17—

Tumor Clinic, Winnipeg General Hospital, 9:00 a.m.

Thursday, 18—

Ward Rounds, Children's Hospital, 11:00 a.m.

Thursday, 18—

Luncheon, Winnipeg General Hospital, 12:30 p.m.

Friday, 19—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

Wednesday, 24—

Tumor Clinic, Winnipeg General Hospital, 9:00 a.m.

Thursday, 25—

Ward Rounds, Children's Hospital, 11:00 a.m.

Thursday, 25—

Luncheon, St. Boniface Hospital, 12:30 p.m.

Friday, 26—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

Friday, 26—

Luncheon, Victoria Hospital, 12:30 p.m.

Friday, 26—

Meeting, Winnipeg Medical Society, 8:15 p.m., Medical College.



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Fortunately, 90% of cases can be cured within a short time with little inconvenience. Clinical records show that the most effective treatment is the administration of gentian violet, in the form of tablets, Vermilet "Frosst". These tablets are specially made to pass undissolved through the stomach and to dissolve in the lower part of the ileum.

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Repeat dose daily for 8 days, rest for one week, then repeat dose for additional 8 days. No patient should be discharged as cured unless 3 or 4 swabs, examined at intervals of a week apart, show absence of ova.

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Winnipeg Medical Society—Notice Board

A. M. Goodwin, *President*

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Next Meeting

April 26th

C. K. Bleeks, *Treasurer*

R. A. MacPherson, *Secretary*

Time flies with such rapidity that the end of the Session is upon us before we realise it. In a few weeks the officers who have guided our destinies during the past year will yield place to their successors and already these have been named. In accordance with Chapter 9, Section 2, of the Constitution the names of candidates selected by the Nominating Committee must be published two months before the date of the Annual Meeting. This year the Nominating Committee consisted of: Drs. McNulty (chairman), Popham, Peikiff, McEachern and Skaling. The following is the list of candidates they submitted:

President	Dr. Walter Tisdale
	Dr. K. C. McGibben
Vice-President	Dr. Cecil Clarke
	Dr. E. T. Holland
Secretary	Dr. R. A. McPherson
	Dr. G. Brock
Treasurer	Dr. C. K. Bleeks
	Dr. Ross Cooper
Trustee	Dr. W. R. Abbott
	Dr. C. R. Rice

The Annual Meeting will be held on May 17th.

The March meeting was devoted to anaesthesia, a subject with which, as is quite proper, Drs. Aikenhead and Lund are making us very conscious. We have certainly travelled a long way since Hugo of Lucca and Theodoric of Cervia taught the use of the sleeping sponge (*spongia somnifera*). All of the "drowsy juices" known to the ancients such as opium, hemlock, mandragora, etc., were mixed together and the sponge soaked in them. Then, after being dipped in warm water, the sponge was applied to the patient's nostrils. The solitary virtue of this method was its safety. There were no deaths from the anaesthetic but then, alas, there was also no anaesthesia. With what envy must these devout humanitarians have read about the "deep sleep" which embraced the subject of the first costectomy; for surgery in their time was no joke. Even a hundred years ago, within the life time, if not within the memories, of men still living, surgery was terrible to contemplate and gruesome to watch. Strong arms and stout cords held the struggling victim upon the table. The knife, often fresh from an autopsy, might be sharpened but was not otherwise cleansed. The surgeon's gown was an old discarded coat, stained and stinking. His hands remained unwashed from morning until noon and often until night. (After

an autopsy and an operation Sir Astley Cooper waited upon the King and, a little anxious at his reception, thought that it might have been "because he had not washed his hands and had blood upon his coat.") An operating room was a scene of suffering and carnage from the second operation to the youth of our grand-parents. The surgeon could show sympathy only by his speed and so, we are told, the knife of Liston flashed with such celerity that a spectator, were he to sneeze, would open his eyes too late to see the amputation. Lister made surgery safe and had his knowledge been known to Liston many would have lived as well as suffered, but they would have suffered and still would suffer were it not for what Dr. John Brown called "one of God's best gifts to His suffering children"—anaesthesia. And Brown well know whereof he spoke as you will remember if you have read "Rab and His Friends."

It is a far cry from Hugo of Lucca to Simpson of Edinburgh but since Simpson's time the distance has been almost doubled. Anaesthesia began her beneficent career as a shy and bashful maiden willing to stay in the background when she was not active with her simple mask and her primitive measures, pleased when the surgeon deigned to cast a glance her way. But all this has changed. First she acquired an art and then developed a science. She is no longer a poor handmaiden but a partner in her own right. The result of this enfranchisement has been a happy one for all concerned. For the surgeon it means greater freedom, for the patient greater safety, for the anaesthetist the satisfaction and the spur of greater responsibility.

Advertisers seldom allow the truth to embarrass them. Not infrequently they proceed on the assumption that if a half lie is repeated often enough it will be accepted as a whole truth and such, indeed, is the case. Take for example the case of the cigarette which has as its slogan "The purest form in which tobacco can be smoked (London Lancet)." Dr. Scarlett of The Calgary Associated Clinic has a note about this in the February issue of the "Historical Bulletin." He writes "I have often wondered about the origin of what is correctly but vulgarly called this "blurb." Recently while browsing through some old volumes of The Lancet I found the answer which was instructive and amusing.

"What The Lancet Has Not Said"

(From The Lancet, Feb. 18, 1905)

"We receive material for a weekly article which could justifiably be published under the above title, for no week goes by without our attention being drawn to the wiles of some enterprising advertiser who is asserting that his wares have received a special commendation from us which the facts do not warrant. Our attention has now been called to the fact that a company calling itself the American Tobacco Company of Canada, Limited, is advertising its 'Sweet Caporal' cigarettes as 'the purest form in which tobacco can be smoked (London Lancet).' We have never said anything of the kind concerning these cigarettes nor have we singled out any cigarette as being composed of the purest tobacco. Some two years ago we made an investigation into the tobacco employed by a certain number of cigarette

manufacturers with the result that we were able to clear Virginian cigarettes from certain accusations of gross adulteration, and we presume that some of the words in our article are held by the American Tobacco Company of Canada to justify its advertising. They do nothing of the sort."

Dr. Scarlett continues: "So there you have it. After more than forty years this particular firm goes on using a slogan that was coined in dishonesty and disowned at its birth. No wonder that advertising, sometimes called the Tenth Muse, is regarded by many as a brazen hussy shunned by decent people, and the source of much mischief in a befuddled world. So far from being a Muse, it is the enemy of the Muses, appealing to the most primitive instincts of fear and lust, and inducing automatic action by means of repetition. In the present instance the indictment of advertising is complete and needs no comment."

Something Old

The Figure of Wax

"My son," asked the Florentine, "do you believe in magic?"

"Fully," returned Charles, repressing a smile of incredulity.

"Well, then," continued Catherine, "from magic proceed all your sufferings. An enemy, who dared not attack you openly, has done so in secret; a terrible conspiracy, the more terrible that it was without accomplices, has been directed against your Majesty."

"Oh, no," said Charles, shocked by that depth of cunning.

"Examine well, my son; recall certain projects of escape which might have assured the safety of your murderer."

"Murderer!" cried Charles; "murderer, do you say? Has anyone, then, tried to kill me?"

"Yes, my son. You doubt it perhaps, but I have gained certain knowledge of it."

"I never doubt what you tell me," replied the king sarcastically. "I am curious to know how they have sought to kill me."

"By magic."

"Explain yourself, Madame?"

"If the conspirator I mean, and whom your Majesty suspects already in your mind,—after having arranged his batteries, sure of success,—had managed to slip away, perhaps no one ever would have known the cause of your Majesty's sufferings. But happily, Sire, your brother watched over you."

"What brother?"

"D'Alenon."

"Ah, true," said Charles with a bitter laugh; "I forgot I had a brother. Well, continue, Madame."

"He very fortunately discovered the clue to the conspirator."

"Ah, I suppose you mean the King of Navarre, Mother?" replied Charles, wishing to see how far her dissimulation would go.

Catherine hypocritically cast down her eyes.

"I have had him arrested and sent to Vincennes for his escapade," continued the king. "He is more culpable than I suspected, then?"

"Do you feel the fever that consumes you?" asked Catherine.

"Yes, to be sure," replied Charles, his brow darkening.

"Do you feel the fire that burns your stomach?"

"Ay, Madame," said Charles, with increasing gloom.

"Do you feel the shooting pains in your head?"

"Yes, yes, Madame. Oh, I feel all that. How well you describe my illness!"

"Well, look here." And she drew from under her mantle a little figure. The figure was of yellow wax, about ten inches high, clothed in a robe covered with golden stars, also of wax, and over this a royal mantle of the same material.

"What is this statue?" asked Charles.

"See what it has on the head," said Catherine.

"A crown," replied Charles.

"And in the heart . . ."

"A needle."

"Well . . ."

"Well, do you recognize yourself?"

"Myself!"

"Yes, yourself, in your royal robes, with the crown on your head."

"And who made this figure," asked the king, weary of the miserable farce, "the King of Navarre, of course?"

"No, Sire."

"No? Then I do not understand you."

"I say no," replied Catherine, "because you perhaps ask the question literally; had you put it in a different manner, I should have answered yes."

Charles made no answer. He tried to read the thoughts of that dark soul which ever closed

itself before him at the moment he thought he was about to read.

"Sire," she continued, "this statue was found by the procureur-general, Laguesle, in the apartment of the man who led a horse for the King of Navarre on the day of the hawking party."

"M. de la Mole?"

"Himself. Now look at the needle in the heart, and the name written on the label attached to it."

"I see an M," returned Charles.

"That means Mort (Death); it is the magic formula."

—Dumas: "Marguerite de Valois."

Book Review

The Journal of the History of Medicine and Allied Sciences. Volume 1, Number 1, January, 1946. Published quarterly by Henry Schurman. New York. \$7.50 per year.

There are many reasons why we should take an interest in things historical. The past is not merely something quaint or amusing; it is also the pattern of the future, for history continues to repeat itself. A knowledge of the past is therefore of practical as well as of cultural value, a fact well known to all serious students of affairs. From the lessons of yesterday we can understand the events of today and can plan for tomorrow. This is obviously true in the world of politics but it is equally true in the world of medicine. How we commenced, how we are progressing and whither we are travelling are taught in the pages of the history of our profession. The same trends, healthy or hurtful, reappear with monotonous regularity. We do not, perhaps, appreciate as we should the tremendous influence we wield in world affairs. In essence it is the doctors who direct the destinies of men and of nations. No other profession has so shaped the fate of the world, for, according to medical skill or lack of it, men have lived or died to the benefit or detriment of the whole race. It is inspiring to read of conquerors who have fought against and overcome the enemies of mankind. But a great surgeon such as Lister and a simple physician such as Jenner have made life possible for a thousand times more millions than all the military conquerors have slain in all the wars of history. These are the names we should think of when we say, "Let us praise famous men," but in the history books which schoolboys read campaigners against nations find more mention than those who made war upon disease.

The student of naval or military affairs, of art or of philosophy has almost an intimate acquaint-

ance with the ancient masters of his subject, and from this familiarity gains inspiration. But the history of medicine is for the most part a sealed book for the modern practitioner who, with his eyes set on the future, sees little of value in the doings of the past. Yet it is only from the past that we can learn and how can we learn if we do not read? Periodicals such as the "Journal of the History of Medicine" should be part of every doctor's reading and the more he reads them the greater will his interest and enjoyment increase.

The following is the table of contents of this number:

Some Galenic and Animal Sources of Vesalius—Sir Charles Singer.

The London Years of Benjamin Waterhouse—Josiah Charles Trent.

A Note on William Blake and John Hunter—Jane Oppenheimer.

Pharmacopoeias as Witnesses of World History—George Urdang.

The Two Earliest Dentistry Woodcuts—Curt Proskauer.

Bernardino Montana de Monserrate: author of the first anatomy in the Spanish Language—J. B. de C. M. Saunders and C. D. O'Malley.

Dr. Benjamin Harrison—P. I. Nixon.

Medical Education in 17th Century England—Phyllis Allen.

Incubator and Taboo—E. H. Ackerknecht.

Animal Substances in Materia Medica: a study in the persistence of the primitive—L. C. McKinney.

Notes and Queries.

J. C. H.

It is better not to know so much than to know so many things that ain't so.—Josh Billings.



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For literature write:

E. R. SQUIBB & SONS OF CANADA, LIMITED, 35-48 Caledonia Rd., Toronto, Ont.

Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

Elsewhere in this issue you will find the Minutes of the February meeting of the Executive Committee of the Association. From now on these meetings will be reported regularly. You will also find the Minutes of the Special Meeting of the Association which was held on March 13th, 14th, and 15th. This "little Convention" was very successful and was exceedingly important. The matters considered and the decisions reached were of great moment to every member and to the Association as a whole. Dr. Hollenberg might well have, for this occasion, changed his patriarchal name from Abraham to Moses, for verily he gave us a glimpse of the Promised Land. His fifteen motions were carried almost unanimously and everyone felt the surge of hope that soon we would all enjoy the juicy fruits of our labours beneath a pleasant vine and fig tree and in a land flowing with milk and honey. Unfortunately for my analogy Moses did not live to enter the Promised Land. Let us hope that it will be otherwise with Abe!

Certainly the new Schedule of Fees fills one with optimism, however flimsy may be its basis. I notice that an Internist may now charge \$25.00 for a "diagnostic investigation." He may also charge \$35.00 for a "neurological examination." How either can be satisfactory or complete without the other I do not see. Does that mean, then, that when our "diagnostic investigation" leads us to the nervous system and we examine the latter that we thereby become entitled to charge \$60.00? And if we decide that surgery is indicated are we entitled to the further fee of \$25.00 for a "pre-operative diagnosis leading to an operation?" If so, who in the names of all the gods at once will pay it? On the other hand if a patient is seen in consultation the work will be the same but the fee suddenly becomes deflated to \$10.00, unless the patient is referred by the D.V.A. in which case it rises to \$15.00 with another \$15.00 if he comes again. It is all very interesting and a bit confusing. But if anyone is inclined to be too enthusiastic I refer him to Dr. Abbott's report which is mostly in red ink.

Indeed the M.M.S. seems to be in a parlous state, suffering from anaemia brought on by a haemorrhage of profits so aptly represented by the ruby figures in the Treasurer's report. Surely with fourteen doctors on the Board something can be done to save the patient's life. Certainly the wealthy parasites who have blood enough of their own should be given a sprinkling of DDT. And some sort of operation is indicated for the tumorous overhead. And it would seem desirable

that the very many who need the service but who do not fit into any of the accepted groups should have provision made for their inclusion. After all our purpose is still the same—to help those who need it. Perhaps if we stopped the bleeding and got a few more vitamins from the B group all would be well.

The body has a brain and also a cerebellum, the function of the latter being co-ordinative. Our Association has need of a cerebellum and such would be the role of a Chairman of the Executive Committee. A paid Secretary is also essential for our future growth and development. The appointment of these officers has been approved and while it means that we shall have to pay larger fees, it means also that we shall get a great deal for our money.

All in all, from what I can gather, this was the best meeting of the Association for many a long day.

An Apology

It is regretted that several of the doctors in the Armed Services were overlooked in the invitation to the Complimentary Dinner given under the auspices of the Manitoba Medical Association and the Winnipeg Medical Society at the Royal Alexandra Hotel on March 14th. This was due to the difficulty in keeping our mailing list up-to-date.

We sincerely apologize to any who were missed.

D. L. Scott, M.D.,
Honorary Secretary,
Manitoba Medical Association.

Contributors in This Issue

Lyon P. Strean, M.Sc., Ph.D., D.D.S., F.A.P.H.A.,
New York City.

John M. McEachern, M.D., F.A.C.P., F.R.C.P.,
Assistant Professor of Medicine, University of Manitoba.

Henry Funk, B.A., M.D., Ch.M.,
Demonstrator in Orthopaedics, University of Manitoba. Orthopaedic Consultant to Ninette and St. Boniface Sanataria.

Roy P. Brown, M.D., L.M.C.C.,
Gladstone, Man.

J. C. Hossack, M.D., M.D.C.M.,
Assistant Professor of Medicine, University of Manitoba.

P. C. Lund, M.D.,
Anaesthetist, Deer Lodge Military Hospital.

Doctors Returned to Civilian Practice From Armed Forces

The following doctors have been discharged from the services and are now back in practice. Their office addresses and telephone numbers are given so that you may easily inform their old patients where they may be found:

Name	Address	Telephone No.
Adamson, Dr. Gilbert L., Winnipeg Clinic, Winnipeg		97 284
Adamson, Dr. J. D., Winnipeg General Hospital		87 681
Alexander, Dr. Walter, 214 Medical Arts Bldg., Wpg.		95 300
Allen, Dr. C. S., 216 Panama Court, Winnipeg		41 185
Anderson, Dr. Julius, 185 Maryland St., Winnipeg		404 065
Austman, Dr. K. J., 704 McArthur Bldg., Winnipeg		95 826
Avren, Dr. S. S., 416 McKenzie St., Winnipeg		59 422
Barrie, Dr. J. G., 11 Rosewarne Ave., St. Vital		204 643
Bellan, Dr. S., 400 Aberdeen Ave., Winnipeg		54 679
Bell, Dr. P. G., Deer Lodge Hospital, Winnipeg		62 821
Bennett, Dr. Wm. J., 12 Newhaven Apts., Winnipeg		33 772
Berger, Dr. M., 428 Anderson Ave., Winnipeg		
Black, Dr. Geo. M., 10 Simcoe Apts., Winnipeg		
Bleeks, Dr. Cherry K., 105 Medical Arts, Bldg., Wpg.		93 273
Bottomley, Dr. H. W., Winnipeg Clinic, Winnipeg		97 284
Boyd, Dr. Wm. J., 1012 Ingersoll St., Winnipeg		24 427
Brotman, Dr. E. H., 1137 Portage Ave., Winnipeg		36 500
Brown, Dr. M. M., 508 Medical Arts Bldg., Winnipeg		93 889
Bruce, Dr. J. D., 20 Buckingham Apts., Winnipeg		96 780
Burch, Dr. J. E., Winnipeg Clinic, Winnipeg		97 284
Bruser, Dr. D. M., 58 Noble Ave., Winnipeg		
Cadham, Dr. R. G., City Hall, Winnipeg		849 122
Carleton, Dr. M., 603 Boyd Bldg., Winnipeg		94 763
Chestnut, Dr. H. W., 25 Knappen Ave., Winnipeg		
Clark, Dr. C. W., 216 Medical Arts Bldg., Winnipeg		94 354
Cohen, Dr. R., 600 Boyd Bldg., Winnipeg		93 275
Coke, Dr. R., Royal Alexandra Hotel, Winnipeg		92 141
Collins, Dr. D. R., Internes' Quarters, Winnipeg General Hospital, Winnipeg		87 681
Cooper, Dr. Ross H., 212 Medical Arts Bldg., Winnipeg		93 103
Corrigan, Dr. C. E., 307 Waterloo St., Winnipeg		401 271
Cram, Dr. J. B., 409 Power Bldg., Winnipeg		95 165
Croll, Dr. L. D., 661 Broadway, Winnipeg		72 138
Davidson, Dr. Kenneth, 6 Medical Arts Bldg., Wpg.		95 683
Davidson, Dr. A. M., 6 Medical Arts Bldg., Winnipeg		95 683
Doupe, Dr. J., 592 Stradbroke Ave., Winnipeg		46 501
Downey, Dr. J. L., 333 Bartlett Ave., Winnipeg		46 751
Easton, Dr. S., 216-7 Curry Bldg., Winnipeg		26 477
Edwards, Dr. K. N., 139 Girton Boulevard Tuxedo, Man.		
Elliott, Dr. M. R., 141 Ferndale Ave., Norwood		
Elvin, Dr. Norman L., 314 Medical Arts Bldg., Wpg.		95 317
Evoy, Dr. G. H., 264 Edmonton St., Winnipeg		94 335
Fahrni, Dr. Gordon S., 105 Medical Arts Bldg., Wpg.		93 273
Fairfield, Dr. G. C., Portage la Prairie, Man.		
Flett, Dr. R. O., 203 Medical Arts Bldg., Winnipeg		92 934
Franks, Dr. Fred, 492 Mountain Ave., Winnipeg		
Govan, Dr. W. R., Abbott Clinic, 409 Power Bldg., Winnipeg		95 165
Guest, Dr. W. C., 151 Yale Ave., Winnipeg		
Gyde, Dr. M. C., St. Pierre, Man.		
Hall, Dr. C. W., 1328 Pembina Highway, Fort Garry, Man.		49 498
Hamilton, Dr. Glen F., 408 Medical Arts Bldg., Wpg.		93 846
Hart, Dr. W. J., Deer Lodge Hospital, Winnipeg		62 821
Hastings, Dr. D. J., 634 Somerset Bldg., Winnipeg		98 727
Helgason, Dr. R. E., Glenboro, Man.		
Henneberg, Dr. C. C., 302 Medical Arts Bldg., Wpg.		92 710
Hillsman, Dr. J. A., 308 Medical Arts Bldg., Winnipeg		97 329
Hitesman, Dr. R. J., 512 Medical Arts Bldg., Wpg.		94 808
Holland, Dr. T. E., 203 Medical Arts Bldg., Winnipeg		96 948
Houston, Dr. A. B., 937 Warsaw Ave., Winnipeg		45 925
Hudson, Dr. J. E., Hamiota, Man.		
Jacks, Dr. Q. D., 410 Medical Arts Bldg., Winnipeg		95 309
Jauvoish, Dr. S., 206 Boyd Bldg., Winnipeg		93 240
Jones, Dr. E. A., Ste. 5, 117 Bryce St., Winnipeg		43 283
Kilgour, Dr. J. M., Winnipeg Clinic, Winnipeg		97 284
Klass, Dr. A. A., 132 Matheson Ave., Winnipeg		55 022
Kobrinsky, Dr. M. T., 968 Strathcona St., Winnipeg		71 498
Kobrinsky, Dr. Sam, 602 Medical Arts Bldg., Wpg.		95 875
Kobrinsky, Dr. Sydney, 505 Boyd Bldg., Winnipeg		93 912
Lansdown, Dr. L. P., Pine Falls, Man.		
Lazareck, Dr. T. L., 616 Aberdeen Ave., Winnipeg		53 674
Lebbetter, Dr. T. A., Winnipeg Clinic, Winnipeg		97 284
Leishman, Dr. J. D., 400 Power Bldg., Winnipeg		96 234
Lerner, Dr. A. I., 211 McIntyre Bldg., Winnipeg		
Loadman, Dr. B. E., Ste. 14A Pullmer Apts., Wpg.		43 601
Lotimer, Dr. L. E., Winnipeg Clinic, Winnipeg		97 284
Lund, Dr. P. C., Deer Lodge Hospital, Winnipeg		62 821
Lyons, Dr. R., 420 Niagara St., Winnipeg		404 009
MacDonnel, Dr. J. A. K. (lady), Winnipeg Clinic		97 284
MacKinnon, Dr. W. B., 661 Broadway, Winnipeg		72 138
MacLeod, Dr. J. W., Winnipeg Clinic, Winnipeg		97 284
MacNeil, Dr. Robt. W., Children's Hospital, Winnipeg		37 271
MacNeil, Dr. Robt. W., Children's Hospital, Wpg.		57 031
McTavish, Dr. Geo. B., 206 Affleck Block, Winnipeg		98 620
Malkin, Dr. S., 701 Boyd Bldg., Winnipeg		97 223
Martin, Dr. J. H., St. Boniface Hospital, St. Boniface, Man.		201 121
Mathewson, Dr. F. A. L., 308 Med. Arts Bldg., Wpg.		94 942
McFarlane, Dr. R. H., Internes' Quarters, General Hospital, Winnipeg		87 681
McIntyre, Dr. Donald N. C., 303 Med. Arts Bldg., Wpg.		92 639
McKenty, Dr. J. Stewart, 514 Med. Arts Bldg., Wpg.		92 711
McKenty, Dr. Jack, 121 Girton Blvd., Tuxedo, Man.		61 777
Maclean, Dr. Ian S., 391 Overdale St., St. James, Man.		61 885
McKenty, Dr. V. J., 205 Boyd Bldg., Winnipeg		94 112
McLandress, Dr. Murray, Apt. "D" Brentwood Lodge, Winnipeg		42 490
McNicol, Dr. H. L., Deer Lodge Hospital, Winnipeg		62 821
Medovy, Dr. Harry, 401 Boyd Bldg., Winnipeg		93 849
Mitchell, Dr. J. R., Ste. 10 Fairhaven Apts., Winnipeg		72 187
Moffat, Dr. R. G., 340 Borebank St., Winnipeg		
Moir, Dr. J. H., 41 Springside Ave., St. Vital, Man.		205 543
Myers, Dr. R. F. M., 15 Clement Block, Brandon, Man.		
Neilson, Dr. Clive, 404 Medical Arts Bldg., Winnipeg		94 041
Perrin, Dr. M. B., Winnipeg Clinic, Winnipeg		97 284
Pickard, Dr. E. W., 118 Lenore St., Winnipeg		
Pierce, Dr. M. M., 354 Stella Ave., Winnipeg		54 134
Rabson, Dr. L. R., 452 Ash St., Winnipeg		
Ramsay, Dr. F. G., 378 Borebank St., Winnipeg		402 669
Revell, Dr. D. G., Winnipeg General Hospital, Wpg.		87 681
Richardson, Dr. R. W., 105 Medical Arts Bldg., Wpg.		93 273
Ridge, Dr. J. M., Clearwater Indian Hospital, The Pas, Man.		
Riley, Dr. H. W., Winnipeg Clinic, Winnipeg		97 284
Rose, Dr. J. E., Winnipeg Gen. Hosp., Winnipeg		87 681
Rosenfield, Dr. V. L., 405 Avenue Bldg., Winnipeg		97 141
Rumball, Dr. A. C., Deer Lodge Hospital, Winnipeg		62 821
Rusen, Dr. S. D., 399 Machray Ave., Winnipeg		58 474
Schoemperlen, Dr. C. B., 216 Medical Arts Bldg., Wpg.		94 354
Smith, Dr. F. Hartley, 86 Tache Ave., Norwood, Man.		203 993
Sommerville, Dr. A. N., 614 St. Mary's Rd., St. Vital		202 411
Sommerville, Dr. A. N., 614 St. Mary's Rd., St. Vital		
Stephens, Dr. Gordon M., 635 Henderson Hy., Wpg.		503 965
Stephenson, Dr. Earl, 409 Power Bldg., Winnipeg		95 165
Stewart, Dr. D. B., 30 Ferndale Ave., Norwood, Man.		205 298
Swartz, Dr. David, 303 Medical Arts Bldg., Winnipeg		92 639
Swan, Dr. R. S., 215 Medical Arts Bldg., Winnipeg		94 354
Tanner, Dr. A. R., 310 Medical Arts Bldg., Winnipeg		95 946
Taylor, Dr. C. H., 606 Boyd Bldg., Winnipeg		98 937
Tisdale, Dr. Paul K., Deer Lodge Hospital, Winnipeg		62 821
Walton, Dr. C. H. A., Winnipeg Clinic, Winnipeg		97 284
Walton, Dr. Fred A., 3 Locarno Apts., Winnipeg		45 719
Whelpley, Dr. E. H., 586 Ingersoll St., Winnipeg		39 061
Winram, Dr. R. G., Ste. 51 Roslyn Apts., Winnipeg		

(Continued on Page 244)

Association Meetings

Executive Meeting

At an Executive Meeting, held on February 17th, 1946, among several items of business on the agenda, the proposal that we hold a special meeting of the Manitoba Medical Association was fully discussed and, as a result of this, it was decided to hold this special meeting in the near future to consider business having to do with The Health Services Act, the employment of a full-time secretary, the Fee Schedule of the M.M.A., to hear a report and discuss the future of the Manitoba Medical Service, and the appointment of an Advisory Committee to the Department of Veterans Affairs, the appointment of Chairman and four members to be made in the following way:

Chairman to hold office for a term of 3 years.
Two members to hold office for a term of two years.
Two members to hold office for a term of one year.
Election to be by proportional representation, the first election to take place at the special meeting called by the President in 1946. The Chairman to be the candidate who receives the highest number of votes; the members for two-year term to be those who receive second and third places in the total number of votes; the members for one-year term to be those who receive fourth and fifth places in the total number of votes.

The above items are not fully reported here because their context is seen in the following Minutes of the Special Meeting of the Manitoba Medical Association.

At this Executive Meeting the dates of the Annual Meeting of the Manitoba Medical Association were discussed and it has been proposed that our meeting this year be a four-day session so that one full day can be devoted to the business of the Association. Tentatively the dates have been set for September 23 - 26 inclusive.

Minutes of Special Meeting

Wednesday, March 13th, 1946, 2:00 p.m.

Present: Approximately 50.

Calling Meeting to Order:

The President, Dr. P. H. McNulty, called the meeting to order. He stated that this special meeting had been called in accordance with paragraph 3 of Article 12 of the Constitution and Bylaws, September, 1945, of the Manitoba Medical Association, to discuss the various matters of importance as slated on the agenda.

The President explained that all voting would be by ballot and that all motions would be posted, so that all might see and study them. He urged everyone to vote.

Introduction by Dr. Archer

Dr. McNulty introduced Dr. A. E. Archer, Liaison Officer of the C.M.A., who had come to Winnipeg to lend his assistance and advice to the Manitoba Division in any way possible during this special meeting.

Contract of Municipal Doctors under "The Health Services Act":

Dr. A. Hollenberg, as Chairman of Committee on Contracts of the Advisory Commission under the Health Services Act, introduced this subject and presented the result of deliberations and principles agreed upon by members of his Contract Committee.

Dr. Hollenberg then moved the adoption of Proposition No. 1 in the proposed memorandum of principles, seconded by Dr. C. M. Strong:

No. 1. THAT where fee for service is contemplated on any contract, the fee charged shall be in accordance with the fee schedule of the Manitoba Medical Association operative at the time of the contract, or in accordance with such revision of the fee schedule as may be made from time to time by mutual agreement of the Manitoba Medical Association and the Commission. **Carried 120 to 2.**

Moved by Dr. A. Hollenberg, seconded by Dr. A. T. Gowron, that Proposition No. 2 be adopted:

No. 2. THAT the optimum number of people that one practitioner shall look after shall be 1,500, with a maximum of 2,000 where circumstances demand. In extenuating circumstances, the maximum number of people to be served by one practitioner may be increased with the approval of the Commission. **Carried 119 to 1.**

Moved by Dr. A. Hollenberg, seconded by Dr. J. M. Matheson, that Proposition No. 3 be adopted:

No. 3. THAT the contract shall provide yearly holidays, sickness leave, and pension at age of 60 on the same basis and scale as that available to Civil Servants of the Province of Manitoba, whose net salary would be that of the Contract Doctor. **Carried 121 to 1.**

Moved by Dr. A. Hollenberg, seconded by Dr. J. R. Martin, that Proposition No. 4 be adopted:

No. 4. THAT provision in the contract shall be made for the attendance at all meetings of the Manitoba Medical Association and District Societies without deduction of pay; and on the approval of the Municipality concerned the doctor may attend the Canadian Medical Association Annual Meeting on the same terms. **Carried 121 to 1.**

Moved by Dr. A. Hollenberg, seconded by Dr. V. F. Bachynski, that Proposition No. 5 be adopted:

No. 5. THAT two weeks every year shall be allowed to a physician for post-graduate study without deduction of salary, allowing for the accumulation of not more than two such periods at any one time. **Carried 118 to 1.**

Moved by Dr. A. Hollenberg, seconded by Dr. F. W. Jackson, that Proposition No. 6 be adopted:

No. 6. THAT the duties of a general practitioner on such a contract shall be:

(a) All medical service within the ability of the doctor, including diagnosis and treatment in the office, in the home, and in the hospital, where a hospital is situated within the bounds of the Municipality;

(b) All normal obstetrics, including outlet forceps;

(c) Minor surgery within the ability of the doctor (minor surgery to be defined by the Manitoba Medical Association and concurred in by the Commission);

(d) No emergency or elective surgery which the practitioner is capable of doing, or dental extractions, or V.D., or treatment of drug addiction, shall be included in the requirements of the Municipal Physician under this contract. These services shall be on a basis of private arrangement between the practitioner and the patient, and the fee shall be in accordance with the prevailing scale of fees of the Manitoba Medical Association or in accordance with such revision of the fee schedule as may be made from time to time by the Manitoba Medical Association and the Commission. **Carried 112 to 8.**

Moved by Dr. A. Hollenberg, seconded by Dr. A. T. Gowron, that Proposition No. 7 be adopted:

No. 7. THAT any practitioner who is engaged for municipal service shall have a six months' probation in the area in which he is located and, if found suitable by the people and vice versa, the contract will then be dated from the date of his first acceptance of the position. **Carried 117 to 2.**

Moved by Dr. A. Hollenberg, seconded by Dr. H. Funk, that Proposition No. 8 be adopted:

No. 8. THAT all contractual disputes are to be settled by the Commission but do not preclude their being taken to court, within the provisions of the law of the land. **Carried 117 to 1.**

Moved by Dr. A. Hollenberg, seconded by Dr. M. Bowman, that Proposition No. 9 be adopted:

No. 9. THAT all contracts shall have provision for cancellation either by mutual agreement between the contracting parties or for just cause. By definition the desire of a physician under such contract to change to another municipal contract shall constitute just cause on his part. **Carried 114 to 3.**

Moved by Dr. A. Hollenberg, seconded by Dr. J. R. Martin, that Proposition No. 10 be adopted:

No. 10. THAT where Municipalities bear the entire cost of medical service, the minimum net salary shall be Four Thousand Dollars (\$4,000.00) per annum, but that, if funds become available from Government sources, this sum shall then be increased to Five Thousand Dollars (\$5,000.00) per annum. **Carried 111 to 7.**

Moved by Dr. A. Hollenberg, seconded by Dr. A. Klass, that Proposition No. 11 be adopted:

No. 11. THAT the Committee on Economics shall endeavor to arrange for yearly increments in salary of a Municipal Doctor up to Two Thousand Dollars (\$2,000.00) after five years beyond the initial salary. **Carried 114 to 4.**

Moved by Dr. F. W. Jackson, seconded by Dr. R. W. Richardson:

No. 12. THAT Dr. A. Hollenberg, Chairman of Committee on Economics, is hereby authorized to continue negotiations towards the achievement of a contract for Municipal Doctors based upon the above eleven propositions. **Carried 112 to 5.**
Committee of Fifteen — Basic Science Act:

Dr. R. W. Richardson, Chairman of Committee of Fifteen, recalled that the Basic Science Bill was assented to by the Manitoba Legislature in April, 1945, which granted license to Chiropractors and Osteopaths to practice the art of healing.

Dr. Richardson briefly reviewed Bills and amendments to Bills which have been passed in the Legislature pertaining to medicine in the past year.

He advised that a Bill was before the Manitoba Legislature at the present time in which a group, under the name of "Natureopaths," was seeking a license to practice their arts of healing. Dr. Richardson asked for direction from this meeting as to what action his Committee should take to combat this group.

Following discussion, in which Drs. O. C. Trainor, W. G. Campbell and C. W. Wiebe took part, it was moved by Dr. C. W. Wiebe, seconded by Dr. A. Moyse:

THAT we instruct the Committee of Fifteen that they do their utmost to prevent the passing of the Bill to license Natureopaths at the present session of the Manitoba Legislature. **Carried 115 to 4.**

Meeting adjourned.

Wednesday, March 13th, 8:00 p.m.

Present: Approximately 175.

The President called the meeting to order and again explained the method of voting by ballot.
Schedule of Fees for Manitoba:

Dr. A. Hollenberg opened discussion on the proposed new Schedule of Fees, printed copy of which was in the hands of each member for study. Dr. Hollenberg stated that this was a schedule we might use in negotiating with Government

bodies, and which we might use in a medical scheme, such as the Manitoba Medical Service. He explained the difficulty in using the schedule now in existence, it not being applicable, especially to specialists.

It was, therefore, moved by Dr. A. Hollenberg, seconded by Dr. J. S. Poole:

THAT the Schedule of Fees, as submitted, shall be adopted by the Manitoba Medical Association as its Schedule of Fees for General Practitioners and Specialists. **Carried 117 to 5.**

Chairman of Executive Committee:

The President stated that the appointment of a Chairman of Executive had been considered by the Executive Committee of the Manitoba Division but, as this necessitated an amendment to our Constitution, the matter was brought before this meeting for discussion. Dr. McNulty explained that this office would be similar to that of the C.M.A. Chairman of Executive Committee, that, with the change in the office of President each year, it would make for continuity and if the employment of a full-time paid Secretary is approved (an item on the agenda for consideration and discussion later on) the holder of this office could act as a sort of liaison between the Executive and the paid Secretary.

Considerable discussion took place and Dr. A. E. Archer, former Chairman of Executive Committee of the C.M.A., explained the workings of the C.M.A. Executive Committee.

It was moved by Dr. J. M. McEachern, seconded by Dr. J. R. Martin:

THAT our Constitution be so changed that Chairman of Executive may be appointed. **Carried 93 to 29.**

Manitoba Medical Service:

Dr. M. R. MacCharles, Chairman of the Board of Trustees, Manitoba Medical Service, opened the discussion and, for the benefit of the men in the Armed Services who were not familiar with the origin of this organization, briefly reviewed its beginning. He stated that five years ago last December the Manitoba Medical Association decided they wished to conduct an experiment on socialized medicine and that a committee of eight men started the ball rolling. A Board of Trustees was later set up, consisting of 14 medical men and 7 laymen.

Dr. MacCharles stated that the Manitoba Medical Service had now been operating 18 months and, in analyzing its experience after a year's operation, it became obvious that there were defects in the scheme.

Plan "A", Surgical, made a profit last year of approximately \$4,600.00, and on Plan "B", Medical and Surgical, a loss was suffered, one reason being

quality of underwriting and another administration costs to M.H.S.A. were too high, between 15 - 16%.

Dr. MacCharles stated that several alternatives had been suggested by the Board to put the Manitoba Medical Service on a paying basis; one was to discontinue selling Plan "B", another was to raise the premium, and still another to cut out some of the services. The general feeling was, raise the price. He further stated that they had their business manager, Mr. Richardson, draw up an estimate of what it would cost to set up a selling organization of their own. He is fairly well satisfied, and we have reason to respect his opinion, that we could do all our own administration for somewhere between 10 - 12%, it now being 15 - 16%.

Dr. MacCharles then asked for expressions of opinion.

Dr. A. C. Abbott, Treasurer of the Manitoba Medical Service, briefly reviewed the balance sheet for 1945, which showed \$19,214.00 paid to M.H.S.A. for administration, \$9,817.00 for salaries, medical claims \$277,000.00, plus sundries; total outgoing \$315,000.00; incoming \$226,000.00; loss for year of \$88,785.00, or \$315.00 per doctor. The question arises: Should we write off this \$88,000.00?

Considerable discussion took place in respect to the various points presented.

It was then moved by Dr. A. Hollenberg, seconded by Dr. A. C. Abbott:

THAT request be made that all deferred accounts of the Manitoba Medical Service be written off. **Carried 103 to 14.**

Moved by Dr. A. Hollenberg, seconded by Dr. H. Funk:

THAT under both Plans, single people making \$1,800.00 and over per annum and married people making \$2,400.00 and over per annum may not have their contracts renewed, and no new contracts be issued to people in this category. **Carried 106 to 13.**

Moved by Dr. A. Hollenberg, seconded by Dr. M. R. MacCharles:

THAT the Manitoba Medical Association request the Board of Trustees of the Manitoba Medical Service to raise the premium to a level that would make Plan "B" solvent. **Carried 102 to 4.**

Meeting adjourned.

Thursday, March 14th, 10:00 a.m.

The President called the meeting to order and introduced Dr. A. E. Archer, Liaison Officer, C.M.A., who presented his observations on "The Health Services Act," Manitoba, following which a discussion took place.

Thursday, March 14th, 2:00 p.m.

Present: Approximately 40.

The President called the meeting to order.

Election of Advisory Committee to Department of Veterans' Affairs:

The President called upon Dr. A. E. Archer, to give a short talk in regard to the conditions existing between the C.M.A. and D.V.A. Dr. Archer outlined what had taken place to date and how this Department would administer treatment services to Veterans.

The President quoted from Minutes of Executive Meeting of February 17th, 1946, in respect to request from Department of Veterans Affairs that the Manitoba Division appoint an Advisory Commission, consisting of Chairman and four members, and the motion passed by the Executive as to the term of office of the members of this Committee and election by proportional representation. He then called upon Dr. R. W. Richardson, Chairman of Nominating Committee, to present his report.

Dr. Richardson presented the following nominations from his Committee:

Dr. F. G. McGuinness
Dr. A. F. Menzies
Dr. C. H. A. Walton
Dr. A. W. Hogg
Dr. Norman L. Elvin
Dr. A. R. Tanner
Dr. G. H. Hamlin

The President then called for further nominations from the floor, and the following were received:

Dr. Wendell Macleod, nominated by Dr. Q. D. Jacks.

Dr. Walter Tisdale, nominated by Dr. C. W. Wiebe.

Dr. George Evoy, nominated by Dr. O. G. Hague.

Dr. C. E. Corrigan, nominated by Dr. A. Klass.
Dr. B. Dyma, nominated by Dr. A. T. Gowron.
Dr. H. Medovy, nominated by Dr. W. G. Campbell.

Dr. Elinor F. E. Black, nominated by Dr. J. R. Martin.

The following doctors were elected to this Committee:

Dr. F. G. McGuinness, Chairman, 3 year term.
Dr. C. E. Corrigan, 2 year term.
Dr. C. H. A. Walton, 2 year term.
Dr. A. F. Menzies, 1 year term.
Dr. Norman L. Elvin, 1 year term.

Full-Time Paid Secretary:

The President advised that a recommendation had been brought in by a Committee of the Executive appointed to study this matter that we employ a full-time paid secretary and the Executive as a whole were in accord with this recommendation. Dr. McNulty stated that the business of the Association has so increased that we feel the need of the services of a full-time man, a high-class secretary, one who knows his business, a man who can go down and talk to the Legislature and find out what they are doing, a man who can talk to labor, who understands their language, who can talk to the industrial man, the farmer and so on. There is only one way to do this, he said, and that is to raise our membership fees. At present 400 members at \$15.00 just floats the Association. A man at \$8,000.00 was the recommendation of the Committee, with travelling and organizing expenses of \$4,000.00—a total of \$12,000.00, and that to meet this additional expense our membership fees be increased to \$50.00.

The President then asked for discussion on this question.

A very lengthy discussion took place, in which Drs. A. Hollenberg, A. M. Goodwin, O. G. Hague, A. Klass, F. W. Jackson, C. H. A. Walton, D. C. Aikenhead, R. W. Richardson, W. H. Gibbs, W. S. Peters and A. E. Archer participated.

Dr. J. R. Martin then moved, seconded by Dr. A. Hollenberg:

THAT the fees of the Manitoba Medical Association be raised sufficiently to provide an amount adequate to engage a full-time secretary and that this fee be on a scale from \$25.00 to \$75.00, on a schedule to be worked out by a special committee appointed for the purpose. **Carried 99 to 19.**

The President thanked the C.M.A., through Dr. Archer, for allowing him to be with us at this time.

The President announced that it is planned to hold a full day business session at our Annual Meeting next September.

This then completed the business session of Special Meeting and motion for adjournment was made.

Following this business session, a Complimentary Dinner to the Manitoba medical officers of the Armed Services was tendered under the joint auspices of the Manitoba Medical Association and the Winnipeg Medical Society, with an attendance of 191 guests and 78 members.

Personal Notes and Social News

Dr. E. H. Alexander has returned from Vancouver, B.C., to conduct pro tempore the practice of Dr. Walter Alexander, who has left for Boston, Mass., to take a three months' intensive post-graduate refresher Eye, Ear and Nose course at Harvard Medical School.

Dr. and Mrs. W. G. Glassco of Brandon, Man., are happy to announce the birth of a daughter (Susan Marion) on February 16th, 1946, at the Brandon General Hospital.

Dr. and Mrs. John M. Malcolm, who have been residing in Winnipeg since Dr. Malcolm's return from overseas, have left for Stettler, Alta., where they will make their future home.

Dr. and Mrs. W. J. Elliott of Brandon, Man., are happy to announce the birth of a daughter (Judith Ann) on March 13th, 1946, at the Winnipeg General Hospital.

Major Lawrence R. Rabson, recently demobilized from the R.C.A.M.C., has passed the examinations for the Fellowship of the Royal College of Surgeons, Edinburgh.

Dr. Walter F. Tisdale was elected president of the Greater Winnipeg Game and Fish Association for the coming year, at a recent meeting of the directors.

Two appointments to the medical staff of the Portage General Hospital have recently been announced. The appointees are Dr. M. E. Bristow, to be consultant in psychiatry, and Dr. C. C. Manly, as consultant in infectious diseases.

Dr. Neil John MacLean was again elected Chief-tain of the Clan MacLean at a meeting of the Clan held at the Marlborough hotel on March 28th.

The sympathies of the Executive and Members of the Manitoba Medical Association are extended to Dr. Cecil Clark on the death of his father, Dr. W. H. Clark, who died March 24th at his home, Portage la Prairie, Man., at the age of 69.

Dr. L. P. Gendreau, recently demobilized from the R.C.A.M.C., has resumed his former practice as assistant physician at the Selkirk Mental Hospital.

Dr. E. W. Pickard, after four years in India with the R.A.M.C., is now attached to the Deer Lodge Hospital as Consultant Surgeon in Plastic Surgery.

Dr. S. S. Avren, formerly with the R.C.A.M.C., has now entered civilian practice with offices at 416 McKenzie Street, Winnipeg.

Dr. W. J. Bennett, who was recently demobilized from the R.C.A.M.C., has now taken up civilian practice at 12 Newhaven Apts., 199 Colony St., Winnipeg.

Dr. H. W. Bottomley, recently demobilized from the R.C.A.M.C., has entered civilian practice as an Associate with the Winnipeg Clinic.

The Typographical Error

The typographical error is a slippery thing and sly;

You can hunt it till you're dizzy, but it somehow will get by.

Till the forms are off the presses it is strange how still it keeps;
It hides behind majuscales, shrinks behind minuscales and never stirs or peeps.

That typographical error, too small for human eyes,
Till the ink is on the paper, when it grows to mountain size.

The editor, he stares with horror, then grabs his hair and groans;
The business manager drops his head upon his hands and moans

The remainder of the Review, clean and error free may be,
But that typographical so and so, is the only thing you see.

The following doctors have recently been demobilized from the Armed Forces, and are now in civilian practice:

Dr. W. C. Guest, Vita, Man.
Dr. H. H. Lippman, Beausejour, Man.
Dr. H. W. C. North, Virden, Man.
Dr. R. T. Watkins, Wawanesa, Man.
Dr. J. H. Riddell, Fort Smith, N.W.T.
Dr. D. B. Stewart, Vita, Man.

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FOR THE TREATMENT OF VITAMIN B COMPLEX DEFICIENCIES

SURBEX is supplied in convenient tablet form and is designed for treating moderate or severe deficiencies of Thiamine, Riboflavin or Nicotinamide accompanied by deficiencies of the other vitamin B complex factors contained in the tablet. One tablet supplies six times the minimum daily requirements of vitamin B₁ and three times that of riboflavin and nicotinamide. It is supplied in bottles of 100, 500 and 1000 tablets.

EACH TABLET CONTAINS

Thiamine HCl	- - - - -	6 Mg.
(Vitamin B ₁ , 2000 Int. Units)		
Riboflavin	- - - - -	6 Mg.
Nicotinamide	- - - - -	30 Mg.
Pyridoxine Hydrochloride (Vitamin B ₆)		1 Mg.
Pantothenic Acid (as Calcium Pantothenate)	- - - - -	10 Mg.
Liver Concentrate*	- - -	5 Grs.
Brewer's Yeast Dried*	-	2½ Grs.

*For Other B Complex Factors

SURBEX SYRUP

A palatable brewer's yeast syrup of high total B complex value.

Each cc contains:

Thiamine (vitamin B₁) (133 Int. Units) . . . 0.4 mg.
 Riboflavin (vitamin G) 0.3 mg.
 Nicotinamide value 4 mg.
 (pellagra-preventive effect equal to about 6.75 gm. of dried brewer's yeast.)

Pantothenic Acid 0.5 mg.

The yeast extract used in this preparation contains other vitamin B Complex factors.

SURBEX ELIXIR

Each cc. contains:

Thiamine Hydrochloride (vitamin B₁) . 0.133 mg.
 Riboflavin (vitamin G) 0.133 mg.
 Nicotinamide 0.666 mg.

(pellagra-preventive effect equal to 2.75 Gm. fresh liver).

Other vitamin B complex factors as present in liver. Each fluid ounce is derived from approximately 40 Gm. (1½ ozs.) of fresh liver.
 Alcohol 12.

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Manitoba Medical Service

The Manitoba Medical Service having been in operation for considerably over a year, it would seem appropriate to ask ourselves was it worth it. The treasurer estimates that the average loss to each doctor was \$350.00; that is to suppose that every doctor's bill would have been paid in full had these members been private patients, a very unlikely event, when it is to be considered that many members in certain groups formerly got their medical attention in outpatient departments and public wards. It must also be remembered that the proportionate amount paid on a bill varies greatly from doctor to doctor, some getting 90%, others about 54%. So far statistical experts have not found a way to correct this.

A constant source of irritation to doctors and administration is the 25% increase to those desiring to confine their work to a specialty; the proviso agreed to by the specialist, and laid down as a regulation by the Manitoba Medical Association, was that the specialist must not go outside his field. Unwittingly many doctors fail to observe this rule; others are placed in the position of having to refuse their services to old friends, to whom they have been in the past, for all practical purposes the family doctor. I imagine that some of them still give those services and never send a bill. Finally, and this is a headache for the director, no definition has ever been accepted which shows a sharp line of demarcation between surgery and medicine. It is rumoured that the D.V.A. scale of fees will solve all their difficulties and I sincerely hope so.

What is to be said on the credit side? For years it has been stated by mouth and in print, and generally accepted that doctors having no business training or outlook could neither organize nor operate a plan of health insurance on a large scale. I think they are perfectly capable of doing so, but in the past they have been so engrossed in the problem of improving the welfare of their individual patients, that they have been unable to give time or thought to the welfare of the community; it is for this reason that governments have gone into the field of public health, mainly in the line of preventive medicine; it would be an optimist who would predict that the same governments, finding how popular their measures have been, will not extend their activities to curative medicine. The only way such a step can be forestalled is by a demonstration that the doctors themselves can meet the demands of the public. The Manitoba Medical Service, feeling that the proof of the pudding lies in the eating, has put to a practical test many of the theories that have been advanced on the subject, and are prepared to question, from the point of view of

experience, many details advanced by our government.

When national health insurance was set up as a political issue in England, most of it was guess work, since neither the government nor the doctors had any idea what types of illness would be encountered, and what services would be needed. The doctors guessed a high figure, the government a low one, and when a deadlock ensued, Lloyd George wielded the big stick, and had his own way.

As might be expected, we have had to meet and overcome many unforeseen difficulties, and there are many more still to be solved. Do you know of any commercial organization that has paid dividends in the first year that it went into operation? Those organizations are usually directed by men skilled in financial and technical methods; I do not think that such men would have made a better job of organizing a health service than the doctors have done. For the comfort of those who willingly backed our venture to the extent of \$100.00 each, I may say that it has not so far been necessary to use the notes held by the treasurer, even for the purpose of obtaining a loan from the bank.

E. S. Moorhead, Medical Director.

(To be Continued)

Administration Notes

3,149 claims, amounting to \$28,303.25, were passed through in January, 1946, and paid on the same basis as previously, to the amount of \$19,296.66 or 68.2%.

Penalization of accounts definitely has improved and it is to be hoped can soon be dispensed with, as this is not only a source of annoyance to you, but also means additional administration on our part.

Secretaries, would you kindly see that sufficient postage is placed on your mail, as we have received a notification of a definite increase of this omission.

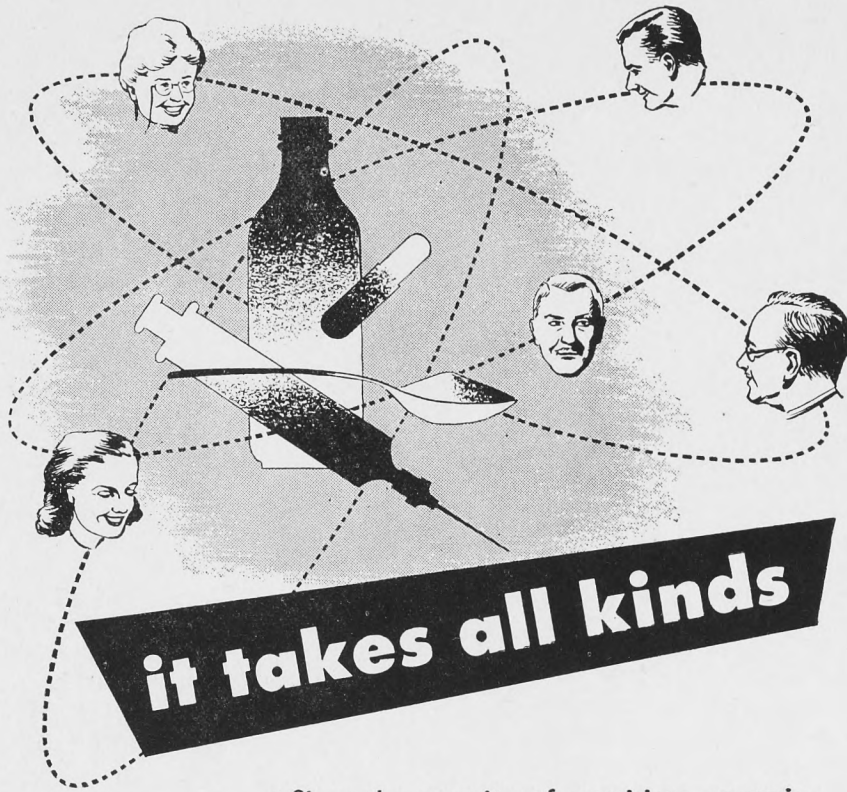
Certain doctors, so far, do not co-operate to the desired extent. That is to be expected, yet this being your Plan, you expect 100% payment. The percentage payment you are receiving would be lower except for the hearty co-operation of your fellow-members.

Enrolment as at January 31st, 1946, was as follows:

Plan A Subscribers	1,628
Plan A Dependents	1,291
	————— 2,919
Plan B Subscribers	10,282
Plan B Dependents	12,749
	————— 23,031

(Continued on Page 255)

25,950



• Since the severity of pernicious anaemia differs widely, treatment is facilitated when a variety of products is available. From the four standardized preparations of Ayerst Liver Extract, the physician can choose the form best suited to the requirements of each patient.

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POWDER (No. 915)—a particularly economical form.

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Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1945		1944		TOTALS	
	Jan. 27 to Feb. 23, '46	Dec. 30, '45 to Jan. 26, '46	Jan. 1 to Jan. 27, '45	Jan. 28 to Feb. 24, '45	Dec. 30, '45 to Feb. 3, '46	Jan. 1 to Feb. 24, '45
Anterior Poliomyelitis	---	---	1	2	---	3
Chickenpox	121	161	271	201	282	472
Diphtheria	14	19	27	45	33	72
Diphtheria Carriers	---	1	8	9	1	17
Dysentery—Amoebic	---	1	---	---	1	---
Dysentery—Bacillary	---	---	1	---	---	1
Erysipelas	3	7	6	3	10	9
Encephalitis	---	---	---	1	---	1
Influenza	27	13	23	24	40	47
Measles	13	39	52	67	52	119
Measles—German	1	1	4	3	2	7
Meningococcal Meningitis	---	1	2	3	1	5
Mumps	139	117	68	172	256	240
Ophthalmia Neonatorum	---	---	---	---	---	---
Pneumonia—Lobar	6	4	14	13	10	27
Puerperal Fever	---	---	---	---	---	---
Scarlet Fever	42	55	60	94	97	154
Septic Sore Throat	3	4	1	3	7	4
Smallpox	---	---	---	---	---	---
Tetanus	---	---	---	---	---	---
Trachoma	---	---	---	---	---	---
Tuberculosis	32	23	16	51	55	67
Typhoid Fever	---	---	2	17	---	19
Typhoid Paratyphoid	---	---	---	2	---	2
Typhoid Carriers	---	---	---	---	---	---
Undulant Fever	---	1	1	2	1	3
Whooping Cough	12	31	44	42	43	86
Gonorrhoea	184	188	117	125	372	242
Syphilis	58	58	42	65	116	107
Diarrhoea and Enteritis, under 1 yr.	7	4	---	---	11	---

DEATHS FROM COMMUNICABLE DISEASE

January, 1946

DISEASES (White Cases Only)	*732,000 Manitoba	*3,825,000 Ontario	*908,000 Saskatchewan	*2,972,000 Minnesota	*641,000 North Dakota
*Approximate population.					
Anterior Poliomyelitis	---	---	---	1	---
Chickenpox	121	1,166	112	---	35
Diarrhoea and Enteritis, under one year	7	---	---	---	---
Diphtheria	14	25	4	60	6
Dysentery—Amoebic	---	---	---	4	---
Dysentery—Bacillary	---	---	---	---	---
Diphtheria Carriers	---	---	4	---	---
Erysipelas	3	6	2	---	---
Influenza	27	437	---	6	55
Jaundice—Infectious	---	28	---	---	2
Measles	13	5,870	16	89	3
Measles—German	1	133	---	---	---
Mumps	139	740	67	---	---
Pneumonia—Lobar	6	---	---	---	---
Scarlet Fever	42	317	18	213	31
Septic Sore Throat	3	10	---	---	1
Trachoma	---	---	---	---	32
Tuberculosis	32	201	59	12	10
Typhoid Fever	---	6	---	---	---
Undulant Fever	---	2	---	17	---
Whooping Cough	12	159	---	34	2
Gonorrhoea	184	772	---	---	52
Syphilis	58	561	---	---	29
Meningococcal Meningitis	---	7	---	16	2
Encephalitis—Epidemica	---	1	---	---	---
Smallpox	---	---	2	---	---
Typhoid Paratyphoid	---	4	---	---	---

Urban—Cancer, 47; Diphtheria, 1; Influenza, 2; Pneumonia Lobar, 4; Pneumonia (other forms), 6; Poliomyelitis, 1; Tuberculosis, 6; Cerebrospinal Meningitis, 1; Diarrhoea and Enteritis, 4; Disease of skin, 1. Other deaths under 1 year, 17. Other deaths over 1 year, 176. Stillbirths, 9. Total, 202.

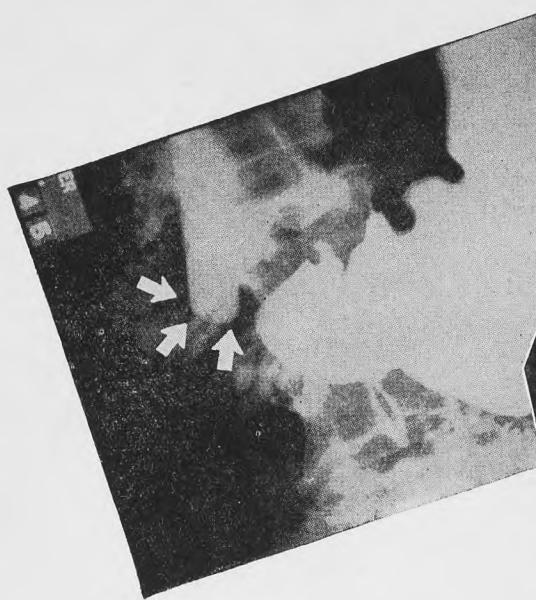
Rural—Cancer, 28; Influenza, 4; Pneumonia Lobar, 3; Pneumonia (other forms), 5; Syphilis, 1; Tuberculosis, 12; Disease of Pharynx and Tonsils, 1. Other deaths under 1 year, 8. Other deaths over 1 year, 95. Stillbirths, 4. Total, 107.

Indians—Pneumonia Lobar, 1; Pneumonia (other forms), 2; Tuberculosis, 3.

Diarrhoea and Enteritis under one year with seven cases reported in Manitoba shows the prevalence of this condition in infants. This disease is a common cause of deaths in young children and may be best controlled by good hygiene, including prevention of infection.

The incidence of **Scarlet Fever** and **Septic Sore Throat** shows that hemolytic streptococci infection is still prevalent.

North Dakota must have had a slight outbreak of Trachoma as thirty-two cases are reported. Although we have been fortunate in Manitoba in recent years we should not forget Trachoma as no doubt there is still infection in the province.

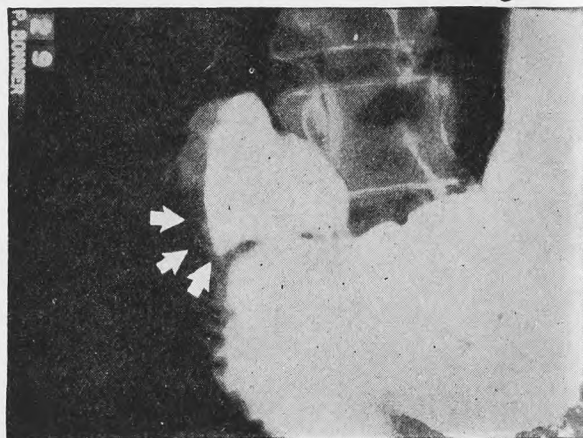


NOT AMINO ACIDS ONLY!

More than two years of clinical investigation, substantiated by roentgenologic evidence, has convinced us that the sole use of the Amino Acids in peptic ulcer therapy is not sufficient. We believe that:

1. The Ulcer should be protected from gastric juice.
2. The healing of the lesion should be stimulated.
3. Nutrition should be enhanced.

The initial dose of Ulcaps is: One every waking hour.



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Department of Health and Public Welfare

Varying Methods of Intensive Mapharsen Therapy for Early Syphilis

1. One-day treatment in which fever therapy and Mapharsen are used, with or without heavy metal.

2. From five to eight days' treatment by varying methods.

3. From ten to twenty days' treatment by multiple syringe injections, with or without fever therapy.

4. Treatment of six weeks' duration or longer in which the frequency of injections vary from two to three each week and the total length of the course varies from six weeks to six months, with heavy metals usually included. The American Army plan of forty Mapharsen and sixteen bismuth injections in a period of twenty-six weeks is a compromise between the short intensive system and the seventy weeks standard regimen.

Dr. Joseph Earl Moore of Johns Hopkins University states that the satisfactory curative course of Mapharsen treatment—that is to say,

that course which will render 85 percent of patients with early syphilis permanently sero-negative, seems to be largely independent of the method of administration. This course to be about 20 - 30 milligrams per kilogram of body weight or a total of 1,000 to 2,000 milligrams for a man weighing 50 - 70 kilograms. If this curative laid-down course is given within ten days or less, serious reactions and a high rate of mortality occur, which are both excessive and unnecessary. Intensive therapy within a one to ten-day period shows one recorded death for each 200 patients treated. The cause of death is generally toxic encephalopathy.

The safest and surest of the above methods comparing favorably with the best of any known methods of treatment today is the twenty-six week American Army method which has been extensively employed by the allies. It is, therefore, given here in detail.

Week		
1	Mapharsen intravenously twice weekly— Total 20 injections	Bismuth Salicylate intramuscularly once weekly — 5 doses
2		
3		
4		
5		
6		
7		
8		
9		
10		
11	Omit Mapharsen 6 weeks	Bismuth Salicylate intramuscularly once weekly — six doses
12		
13		
14		
15		
16		
17	Mapharsen as in first course — twice weekly — total 20 injections	Omit Bismuth 5 weeks
18		
19		
20		
21		
22		
23		
24		
25		
26		
		Bismuth Salicylate intramuscularly once weekly — 5 doses

Mapharsen Dosage: Adjusted approximately to body weight. Average dose 60 mgm.; minimum dose 50 mgm.; maximum dose 70 mgm.

Bismuth Subsaliolate in Oil Dosage: 0.2 gm. (With Stabisol this amount to be 1½ cc.)

Post-Treatment Follow-up in Penicillin Treated Syphilis

Penicillin has been used for many patients in the armed services who have now returned or are returning home. Most of them will have

received 2,400,000 units, given in 60 consecutive intramuscular injections of 40,000 units each at three-hour intervals day and night for 7½ days. Commonly 4 or 5 Mapharsen and 2 or 3 bismuth salicylate injections have also been given during the same period of time. Only the future can determine how many of these patients will relapse.

As many civilian physicians will have the responsibility of following up these patients a few words on clinical and serological post-treatment course and also definition of failure is in order.

Serologic Course

In primary and secondary syphilis the titre of the Wasserman test declines gradually from positive to negative in the post-treatment period, the negative phase being achieved in a variable time. The majority of cases become negative between the second and fourth post-treatment months, although earlier and later reversals occur. On the basis of present information the critical period for relapse, both clinical and serologic, appears to lie between the third and sixth post-treatment months, although relapses have been observed at earlier and later periods.

In latent syphilis the serologic curve may take the same course as that observed in primary and secondary syphilis, notably those which have only recently passed from the secondary phase into the phase of latency. On the other hand, individuals with older latent syphilis are likely to exhibit serologic refractoriness, the serologic test showing little or no tendency to fall.

Penicillin Failure

Care should be experienced in the determination of failure since patients may develop intercurrent skin eruptions of nonsyphilitic character. Intercurrent infections and Smallpox vaccinations may produce a temporary elevation of the titre of the serologic test. All forms of clinical relapse are generally accompanied by serologic relapse, or by persistently high serologic titres.

Treatment failures may be divided into seven categories:

1. Mucous and/or cutaneous relapse is manifested by the appearance of syphilitic lesions of the mouth, genitals and skin, the latter especially in the anogenital region. Darkfield examination should corroborate the diagnosis. If Darkfield examination is negative, repeated serologic tests should be performed.

2. Serologic relapse is manifested by a rising titre after the test had become negative or has previously manifested a falling trend. When a serologic relapse is suspected, the patient should be thoroughly and completely examined, since serologic relapses are usually accompanied or

shortly followed by mucocutaneous or some other clinical relapse.

3. Serum-fastness in primary or secondary syphilis is manifested by a failure of the serologic test to show a marked decline within an arbitrary period of six months after completion of therapy. Minor fluctuations may occur but there is no consistent gradual and maintained fall to negative. The condition will apparently be uncommon in primary and secondary syphilis, where it will be considered a treatment failure when present six months after completion of therapy. It will not be uncommon in latent syphilis, in which it will not be considered a treatment failure.

4. Neurologic relapse (neuorecurrence) may occur as acute syphilitic meningitis, with headache, dizzy spells, fever, and rigidity of neck. In fulminant cases, coma may supervene rather rapidly. Less commonly relapse in the nervous system may appear as an isolated cranial nerve palsy or paralysis of one or more extremities. Diagnosis should be confirmed by spinal fluid examination and a neurologist should be consulted for diagnostic assistance.

5. Asymptomatic neurosyphilis is manifested only by abnormal spinal fluid.

6. Ocular relapse may be manifested by iritis, usually unilateral, or optic neuritis, or neuroretinitis, which may be unilateral or bilateral. An ophthalmologist should be consulted.

7. Osseus relapse is manifested by severe pain, often nocturnal, in the long bones, most often the tibial, or severe headaches when cranial bones are affected. Local tenderness is often very acute.



A Lawyer Speaks to Doctors

On November 19, 1945, President Truman delivered to Congress a message on a national health program which marks an important milestone on the long road toward public health. It includes the five basic elements which have entered into all informed discussions of this subject: provision of hospitals and related facilities for areas now lacking service of this kind; expansion of public health services, particularly those related to maternity and infancy; advancement of medical education and research; a comprehensive plan of prepayment for medical care; and extension of social security to cover the hazards of sickness and disability. It is a bold and statesmanlike document—a clarion call to action.

The exact form of legislation to carry out these purposes will come before the Congress and the people during succeeding months. Discussions of details must await their concrete formulations. As a preparation for reasonable

discussion, we urge preliminary study of an article presented in Public Health Reports for January 5, 1945. If your volume has not been bound as yet, dig this number out of your files. Take it with you on a train or in a bus and read an address by Wendell Berge, Assistant Attorney-General of the United States, on "Justice and the Future of Medicine," delivered before the American Urological Association. It is one of the clearest and fairest analyses of the basic principles which should govern our planning for medical care which have yet appeared in print.

Mr. Berge makes three points of major importance. The first of these is his emphasis on the fact that medical service as an actuality involves social and economic as well as medical factors. He recognizes that this problem is "unusually baffling. For it is only the exceptional person who has experienced all the arts—technical, economic, cultural—which converge in it. A beginning of understanding lies in a recognition of a distinction between the technology of medicine and its organization. By technology I mean all of those arts of diagnosis, therapeutics, surgery, radiology, dentistry, and the like, which constitute the profession of medicine. By organization I mean all of the arrangements, social and economic, by which medical service is made available. It is idle to dispute as to which is the more important; for there must be a medicine to practice, and there must be arrangements for bringing physician and patient together. It is no veiled mystery as to which is the more backward. In the advance of the art of medicine, you have done a brilliant job. In the face of this advance it is all the more tragic that progress in the organization of medicine has lagged, and because of this lag, the nation has not had the full benefit of your superlative performance."

With regard to the problems of organization of medical service—as distinct from the practice of the medical arts—Mr. Berge points out that "as a group, physicians have been little exposed to the discipline of the social sciences, and social organization is as intricate and as full of mysteries as the art of medicine itself. So when I hear a physician sreaking about the organization of medicine in a tone of doctrinaire finality, I cannot fail to remark the contrast with the courageous and humble search for truth displayed in his own work. And when I hear the question put as a choice between private practice and socialized medicine, I cannot escape noting a confusion and dogmatism strikingly different from the scientific approach. As for the 'either or' of private practice and socialized medicine, there is no such question. There are a myriad of schemes under which the doctor and the patient may be brought together—not a choice between just two." There

is "no such question as private practice versus socialized medicine. For practice is never private and all medicine has a social function."

Mr. Berge deals effectively with the claim that no other system than individual financially-competitive medical service can safeguard quality of medical care, as essentially intimate personal relation between physician and patient and the morale and initiative of the physician. "Such values," he says, "depend upon no one single way of organizing medicine. To say that a doctor will give his utmost if he acts as his own business agent, and that his incentive will be stifled if he receives a salary, is not borne out by experience. The time was when the great scientific advance was the work of the solo inventor. Today the most creative of all work, the progress of science and the useful arts, is the product of men on salary. In the larger offices the great mass of lawyers now work on salary and work as hard and as heroically as the youngster who used to flaunt his own shingle in the breeze. It is true that the chance to become a partner is an incentive, but I would not rank it overly high, for work equally as good is done by the lawyers in the Government, where no such opportunity exists. In our institutions of higher learning, research as well as teaching falls to salaried employees and there you will observe an interest, excitement, devotion to duty, an urge to be up and doing. To return to medicine, how many thousands of our best doctors are today giving their all without stint in the service of the Army and the Navy?

"Ambition, security, income are necessary things. They have in every age and among the most varied conditions of society driven men to accomplishment. If I were a youngster, I would rather leave the series of judgments which shape my career to men of my own profession than attempt to get ahead by translating my skills into the art of winning and holding patients."

Mr. Berge's third emphasis is on the inevitability of changes in the present system of medical services and on the importance of medical participation in planning such changes. "The arts of medicine," he tells us, "have advanced; the importance of medicine has been enhanced; it has become a necessity to the people and an essential in the operation of the industrial system. It has outgrown the organization into which, in days of petty trade, it was cast. The demand is for a vaster, more comprehensive, more reliable medical service. If an instrument of the common health can be provided on terms the people can afford, the people will rejoice. If you do not help them to do it, the people will seize upon whatever agencies are at hand as a help in time of need, for the universal demand that the common

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Chemists and Druggists, Sept. 15th, 1945.

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health be served cannot much longer be stayed.

"A new medical order is inevitable. Whether we shall cling to the old order or create a new one is not the question. The swift course of events has decreed that there can be no turning back. The question is rather what sort of a medical order it is going to be and whether it is the best wisdom and knowledge can contrive. Like every promising venture, it has its hazards. Is it to be shaped by the best understanding which law, medicine, and the social studies can bring to it? Or is it to be constructed by amateurs in ignorance but with good intentions?"

He makes the following final plea to the medical profession: "I can hand you no ready-made medical order on a silver platter. If I could it would do you no good. I can only suggest to you, whose minds have long been busied with the subject, some reflections of a man of another profession. And I am positive that a service adequate to the times cannot be brought into being without the doctors' creative participation. As doctors and patients we face a crisis, and my appeal is to the ancient wisdom of the profession. The ends of medicine remain unchanged; ways and means must be found to adapt its practice to the conditions of present-day society. A new organization must be created that an ancient mission be not lost, that once again medicine shall be available to all in need and charges shall be graduated in accordance with ability to pay."

"An instrument of the common health such as never before has been offered to a people is within our reach. This is no time for petty doubts and timid moves. In the face of a national challenge we must, as one of our great jurists said of the law, let our minds be bold."

The above is a summary of an address given by the Assistant Attorney-General of the United States on "Justice and the Future of Medicine," delivered before the American Urological Association. The summary is from the January issue of the American Journal of Public Health.

Doctors Returned to Civilian Practice from Armed Forces

(Continued from Page 226)

Brook, Dr. Joseph	Beausejour, Man.
Bissett, Dr. E. D. R.	Pine Falls, Man.
Brownlee, Dr. T. I.	Russell, Man.
Crawford, Dr. C. S.	The Pas, Man.
Davidson, Dr. D. A.	Cartwright, Man.
Jacobs, Dr. A. L.	The Pas, Man.
Varverikos, Dr. E. D.	Selkirk, Man.
Gendreau, Dr. L. P., Mental Hospital	Selkirk, Man.
Corbett, Dr. Connor A.	Crystal City, Man.
Luginsky, Dr. S. M.	Beausejour, Man.

College of Physicians and Surgeons of Manitoba

Annual Meeting

Winnipeg, Man., October 17th, 1945.

The Sixtieth Annual Meeting of the Council of the College of Physicians and Surgeons of Manitoba was held Wednesday, October 17, 1945, at 2.00 o'clock p.m., at the Medical College, Winnipeg.

The President, Dr. H. Bruce Chown, called the meeting to order.

The business of the meeting was as follows:

1. Roll Call.

The following members were present: Dr. H. Bruce Chown, President; Dr. A. A. Alford, Dr. I. H. Beckman, Dr. B. D. Best, Dr. W. G. Campbell, Dr. W. E. R. Coad, Dr. H. O. McDermid, Dr. A. E. McGavin, Dr. J. S. Poole, Dr. James Prendergast, Dr. W. F. Stevenson, Dr. C. B. Stewart, Dr. N. G. Trimble, Dr. Wm. Turnbull, Dr. T. Digby Wheeler, Dr. C. W. Wiebe.

The Registrar, Dr. W. G. Campbell, stated that he had received a letter from Dr. D. G. Ross, explaining that he had moved to Toronto, as he was no longer practicing on account of his health,

Motion:

Moved by Dr. W. G. Campbell, Seconded by Dr. N. G. Trimble: "THAT a letter of appreciation be sent to Dr. D. G. Ross from the Council." Carried.

2. Reading of the Minutes and Their Approval.

The minutes of the Special Meeting of the Council held May 18th, 1945, were presented.

Motion:

Moved by Dr. T. Digby Wheeler, Seconded by Dr. B. D. Best: "THAT the Minutes of the Special Meeting of the Council held May 18th, 1945, be accepted as having been read." Carried.

Business Arising from the Minutes of Council Meeting May 18th, 1945

- (a) Registration of Dr. T. A. Lebbetter.
- (b) Re highly qualified specialists; under report of Education Committee.
- (c) Administration of Basic Science Act; under report of Committee of Twelve.

3. Reports of Officers and Their Consideration.

(a) Registrar's Report.

"May I, your Registrar, report briefly at this the Sixtieth Annual Meeting of the Council of the College of Physicians and Surgeons of Manitoba.

"May I thank the members of the Council and of the Committees for the harmonious assistance rendered throughout the past year.

"During the coming few years undoubtedly problems will arise in the re-establishment of medical officers from the armed forces. I hope the Council may give this matter due consideration at this or subsequent meetings, and establish

an elastic policy for the guidance of the Registration Committee and of your Registrar.

"Has the time arrived when the Council may see fit to re-establish its former policy, that medical appointments in the Government institutions should be registered in this Province?

"Will this Council now see fit to proceed with the registration of all graduate internes in Manitoba hospitals as was in progress of establishment before the outbreak of war?

"May I again draw the attention of the Council to the health proposals submitted by the Dominion Government and the Provincial Legislature? Would it not be advisable that this Council take some action in the formulation of the proposed plans submitted, and thereby guide the betterment of the future practice of medicine?

"May I draw the Council's attention to the Election to the Council which will occur in 1946 according to by-law.

"Eleven (11) Life Membership certificates were issued during the year.

"Number of Registrations—Twenty-two (22).

"Number of registered doctors, as of October 17th, 1945:

Greater Winnipeg	349
Outside Winnipeg	177
	526
"Licenses—22 @ \$100.00	\$2,200.00
Certificates:	
M.C.C.—72 @ \$5.00	360.00
G.M.C.— 1 @ \$5.00	5.00
Annual Fees	788.00
Medical Student Registrations:	
52 @ \$1.00	52.00
	\$3,405.00

"The following is a list of the members of the College of Physicians and Surgeons of Manitoba who have deceased during the year:

Allan, R.	Calgary, Alberta
Barnes, E. C.	Victoria, B.C. (formerly Selkirk)
Bond, J. H. R.	Winnipeg, Manitoba
Cameron, A. A.	Winnipeg, Manitoba
Davis, R. E.	St. James, Manitoba
Hay, A.	Winnipeg, Man. (died in England)
Hislop, J. A.	Edmonton, Alberta
Laurendeau, N. A.	St. Boniface, Manitoba
MacKinnon, A. P.	Winnipeg, Manitoba
McFarlen, H. A.	Winnipeg, Manitoba
Magee, R. C. E.	Winnipeg, Manitoba
Netterfield, W. C.	St. James, Manitoba
Shubin, A. L.	Winnipeg, Manitoba
Sigvaldason, J. M.	Ninette, Manitoba
Simpson, R. M.	Winnipeg, Manitoba
Volume, D. A.	Bayfield, Ontario

Walker, S. B. West Summerland, B.C.
 (formerly Winnipeg)
 Waugh, R. J. Carberry, Manitoba."
 Respectfully submitted,
 W. G. Campbell.

Motion:

Moved by Dr. W. G. Campbell, Seconded by Dr. B. D. Best: "THAT the Registrar's Report be adopted." Carried.

(b) Treasurer's and Auditor's Report.

Dr. T. Digby Wheeler presented the following reports:

Gentlemen:

The following is submitted as the Treasurer's report for the year ending September 30th, 1945. Submitted also is the Auditor's Report covering the same term. Your Treasurer wishes to make some observations regarding our funds and expenditures.

Gordon Bell Memorial Fund

The capital of this fund remains at \$20,000.00. There has been added to this the sum of \$1,900.00 representing unexpended interest which has also been invested in War Bonds. There is now on deposit in the Gordon Bell Savings Trust Account \$1,806.86. This, of course, represents further accrued interest as the fellowship has not been awarded during the last few years. It would seem advisable that \$1,000.00 of this amount be invested in the present War Loan which would leave \$806.86 to take care of the awarding of a fellowship that occurs during the next year. Your Treasurer is prepared to make a motion to this effect. Dr. H. V. Rice was awarded his fellowship a year ago, but during the current year has only received a disbursement of \$75.00, as he found himself unable to continue this research and the fellowship was discontinued.

Investment Trust Account

The principal of this account now stands at \$35,800.35. This is a marked contrast with my report of a year ago when the principal of this account stood at \$44,060.25. It has been necessary for us during the last year to sell bonds in the amount of \$9,185.83. This amount has been transferred to Current Account in order to take care of our excess expenditures over revenue in the last two years. I am not at all happy regarding the situation of the Investment Trust Account. It does not take a mathematician to determine the length of time it would take to completely exhaust our capital in this account if our present rate of expenditures continues. It is quite true that during the two years we have had some unusual expenditures. Another factor in the depletion of this account has been our loss of revenue because so few men have registered for practice in Manitoba during the war years.

Current Account

I make the same remark regarding this account as of last year, in that it represents a most unsatisfactory condition. Our expenditures exceeded revenue in the amount of \$4,672.61. As pointed out above this money had to be transferred from the Investment Trust Account. Our current deficits must be considered to be \$750.00 more than the above figure because we have extended a large credit to the Medical College Library in the amount of \$750.00, and none of this money has been called. It is an obligation that we must assume for the next year.

All of which is respectfully submitted.

T. Digby Wheeler.

Price, Waterhouse & Co.

The College of Physicians and Surgeons of Manitoba,

Winnipeg, Manitoba.

Dear Sirs:

In accordance with the instructions of your Registrar, we have made an examination of the books and records of The College of Physicians and Surgeons of Manitoba for the year ending September 30, 1945, and for your information we submit the following statements:

Gordon Bell Memorial Fund	Exhibit I
The Investment Account	Exhibit II
Current Account	Exhibit III

In connection with these statements and our examination of the records we would offer the following comments.

The investments and funds of the College as at September 30, 1945, further particulars of which are contained in the attached exhibits, may be summarized as follows:

Gordon Bell Memorial Fund:

Dominion of Canada Bonds (Par value \$21,900.00)	\$21,900.00
Uninvested funds on deposit with the Bank of Toronto	1,806.86
	<u>\$23,706.86</u>

Investment Account:

Dominion of Canada Bonds (Par value \$35,000.00)	\$35,800.35
Uninvested funds on deposit with the Bank of Toronto	2,174.82
Amount advanced to the Current Account	9,821.79
	<u>47,796.96</u>

Current Account:

Balance on deposit with the Bank of Toronto as per books, September 30, 1945	\$ 635.96
Deduct —Amount due to the Investment Account	9,821.79
	<u>9,185.83</u>
	<u>\$62,317.99</u>

Dominion of Canada Bonds

We attended at the safety deposit vaults of the Bank of Toronto on October 5, 1945, and in

conjunction with Dr. R. D. Wheeler and Dr. W. G. Campbell, examined the Dominion of Canada bonds of a par value of \$35,000.00 as shown under the heading of Investment Account. With the exception of four \$100.00 bonds under the heading of Gordon Bell Memorial Fund, which are registered only as to principal, the bonds examined by us were seen to be fully registered in the name of The College of Physicians and Surgeons of Manitoba.

During the year Dominion of Canada bonds of a par value of \$8,000.00 were sold from the Investment Account. This sale was authorized in the minutes; particulars of the transaction, together with the opening and closing balance of the investments, are shown below.

Investments—September 30, 1944		\$44,060.25
Deduct—Book value of bonds sold:		
	Par Value	Book Value
3 per cent bonds due June 15, 1951	\$4,000.00	\$4,000.00
3 per cent bonds due March 1, 1954	1,000.00	1,000.00
3 per cent bonds due November 1, 1956	1,000.00	1,000.00
4½ per cent bonds due November 1, 1956	1,000.00	1,000.00
3 per cent bonds due May 1, 1957	1,000.00	1,000.00
	<u>\$8,000.00</u>	<u>8,115.00</u>
		\$35,945.25
Less—Excess of sale proceeds over book value applied to write down book value of remaining investments		<u>144.90</u>
Book value—September 30, 1945		<u>\$35,800.35</u>

The above sales proceeds were, as indicated on Exhibit II, applied in paying off the demand loan from the Bank of Toronto and making a further advance to the Current Account. In this connection it might be noted that the interest on the demand loan was charged up as a disbursement on Current Account but with that exception no interest is charged to Current Account in respect of the moneys advanced to it by the Investment Account.

Funds on Deposit

The balances on deposit with the Bank of Toronto at September 30, 1945, in the two savings accounts and the current account have been reconciled with a certificate received by us direct from the bank.

Receipts and Disbursements

With the exception of the funds on deposit in the current account, which account is non-interest bearing, we have seen that interest has been received on all investments and funds. In the case of the current account we have checked the stubs of receipts issued by the Registrar in connection with licenses, certificates and annual fees

against the book entries but have not taken any further steps to verify the correctness of the contributions from members of the College.

In regard to payments from the Gordon Bell Memorial Fund and the Investment Account, we have seen cancelled cheques drawn on the savings accounts.

In connection with the Gordon Bell Memorial Fund we examined evidence in support of the fellowship awarded for the year 1944-1945 as shown hereunder:

Dr. H. V. Rice.....\$75.00

During the year ending September 30, 1944, there was paid to Dr. Rice an amount of \$225.00 which was on account of the above fellowship. In this regard we are informed that Dr. Rice was unable to continue his research work and an amount of \$75.00 only is recorded as paid during the current fiscal year.

With regard to disbursements from the current account we have seen cancelled cheques or other evidence in support of the items appearing in the books. As the statements submitted relate only to cash receipts and disbursements, we have not gone into the question of any arrears in respect of fees outstanding or outstanding liabilities as at September 30, 1945.

We examined the minutes of the College and would point out that no authorization was recorded therein in respect of the salaries for the fiscal year ending September 30, 1945, of the Registrar and Treasurer; it would seem to us that this matter should be a subject of consideration at the next annual meeting in accordance with the by-laws of the College.

We shall be pleased to furnish you with any additional information you may desire in regard to the attached accounts.

Yours very truly,

Price, Waterhouse & Co.

Exhibit I

The College of Physicians and Surgeons of Manitoba Gordon Bell Memorial Fund

Statement of the Fund September 30, 1945

Investments

Dominion of Canada bonds in the name of The College of Physicians and Surgeons of Manitoba:

Fully Registered:

3 per cent Victory Loan, due 1951.	
1 bond of \$500.00 numbered K4 Z020847, carried at par	\$ 500.00
3 per cent Victory Loan, due 1957.	
1 bond of \$1,000.00 numbered L4 M39923, carried at par	1,000.00
4½ per cent Conversion loan due 1958.	
2 bonds of \$10,000.00 each, numbered X4677 and X4678, carried at par	20,000.00

Registered as to principal:

3 per cent Victory Loan due 1951.	
4 bonds of \$100.00 each, numbered K4 A169573, A169574, A169575 and A169576, carried at par	400.00

\$21,900.00

Funds on deposit with the Bank of Toronto	1,806.86
	<u>\$23,706.86</u>
Accounted for	
Balance of the fund, October 1, 1944:	
Invested	\$21,900.00
Uninvested	919.15
	<u>\$22,819.15</u>
Increase during the year ending September 30, 1945, being excess of revenue receipts over disbursements	887.71
	<u>\$23,706.86</u>

Statement of Transactions	
Year Ending September 30, 1945	
Balance of uninvested funds, October 1, 1944	\$ 919.15
Revenue Account	
Receipts:	
Interest on Dominion of Canada Bonds	\$ 957.00
Interest on uninvested funds	5.71
	<u>\$ 962.71</u>
Disbursements:	
Fellowship paid to Dr. H. V. Rice	75.00
Excess of receipts over disbursements	887.71
Balance, September 30, 1945	<u>\$ 1,806.96</u>

Exhibit II

The College of Physicians and Surgeons of Manitoba
The Investment Account
Statement of the Fund September 30, 1945
Investments

Dominion of Canada bonds fully registered in the name of The College of Physicians and Surgeons of Manitoba:	
4½ per cent loan due 1956:	
3 bonds of \$10,000.00 each, numbering X0522, X0523 and X0527 and 1 bond of \$5,000.00 numbered V0419, aggregate par value \$35,000.00, carried at a net book value of	\$35,300.35
3 per cent Victory Loan due 1957:	
1 bond of \$500.00 numbered L4 Z45631, carried at par	500.00
	<u>\$35,800.35</u>
Funds on deposit with the Bank of Toronto	\$ 2,174.82
Amount of advances to the Current Account	9,821.79
	<u>11,996.61</u>
	<u>\$47,796.96</u>
Accounted for	
Balance of the fund, October 1, 1944:	
Invested	\$44,606.25
Uninvested	527.65
Amount advanced to the Current Account	5,500.00
	<u>\$50,087.90</u>
Deduct—Demand loan due to the Bank of Toronto	4,000.00
	<u>\$46,087.90</u>
Increase during the year ending September 30, 1945, consisting of revenue receipts	1,709.06
	<u>\$47,796.96</u>

Statement of Transactions**Year Ending September 30, 1945**

Balance of uninvested funds, October 1, 1944	\$ 527.65
Add—Realization of invested funds:	
Dominion of Canada bonds of a par value of \$8,000.00, having varying maturities and interest rates and carried in the books at \$8,114.00 (see report page 2)	8,259.90
	<u>\$ 8,787.55</u>

Revenue Account

Receipts:	
Interest on Dominion of Canada bonds	\$1,642.50
Add—Accrued interest on sale of bonds at a par value of \$8,000.00	61.89
	<u>\$ 1,704.39</u>
Interest on uninvested funds	4.67
	<u>1,709.06</u>
	<u>\$10,496.61</u>
Deduct:	
Demand loan to Bank of Toronto paid off	\$ 4,000.00
Additional advance to the Current Account during the year	4,321.79
	<u>8,321.79</u>
Balance, September 30, 1945	<u>\$ 2,174.82</u>

Exhibit III

The College of Physicians and Surgeons of Manitoba
Current Account
Statement of Cash Receipts and Disbursements
From October 1, 1944, to September 30, 1945

Receipts	
Licenses	\$ 2,200.00
Certificates:	
M.C.C.	\$ 360.00
G.M.C.	5.00
	<u>365.00</u>
Annual fees	788.00
Medical students' registration fees	52.00
	<u>\$ 3,405.00</u>
Disbursements	
Salaries:	
Registrar—Dr. W. G. Campbell	\$1,200.00
Treasurer—Dr. T. D. Wheeler	200.00
Secretary—Miss Jean Allison	499.36
Mrs. W. M. Campbell	15.00
Meetings:	
Annual, October, 1944	\$ 336.60
Special, May, 1945	346.60
Executive Committee	121.70
Special Committees	48.90
	<u>853.80</u>
Grants:	
Manitoba Medical Service Association	\$3,000.00
Winnipeg Medical Society, re parcels for doctors overseas	100.00
	<u>3,100.00</u>
Legal fees:	
Williams, Dilts, Baker, Laidlaw and Hamilton re Health Act	\$ 75.00
Williams, Dilts, Baker, Laidlaw and Hamilton re Chiropractors, Basic Science and Osteopathic Acts	1,000.00
Provincial Treasurer—Filing fees, 1932 to 1944	52.00
	<u>1,127.00</u>

Janitor's services, Annual and Special	
Meetings	10.00
Office rental	300.00
Insurance premiums	22.50
Auditors' fee	75.00
Printing and stationery	299.95
Postage	97.00
Exchange on cheques	7.83
Miscellaneous office expense	39.50
Unemployment insurance	2.89
Business tax	22.50
Interest on demand loan	68.65
General Expense	4.00
Manitoba Medical Association re expenses of extra-mural lectures	80.53
Annual fees refunded	2.00
	<hr/> \$ 8,027.51

Excess of disbursements over ordinary receipts for the year	\$ 4,622.51
Deduct—Amount advanced from the In- vestment Account	4,321.79
	<hr/>
Excess of disbursements over receipts	\$ 300.72

**The College of Physicians and Surgeons of Manitoba
Current Account**

**Statement of Cash Receipts and Disbursements
From October 1, 1944, to September 30, 1945**

Summary

Cash in bank as per books, October 1, 1944	\$ 936.68
Deduct—Excess of disbursements over receipts	300.72

Balance of cash in bank as per books, Septem- ber 30, 1945	\$ 635.96
Deduct—Amount due to the Investment Account	9,821.79

Current Account deficit as at September 30, 1945	\$ 9,185.83
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Balance in bank account with Bank of Toronto, September 30, 1945	\$ 659.96
Deduct—Outstanding cheque: Dr. A. A. Alford	24.00
	<hr/>
	\$ 635.96

Motion:

Moved by Dr. T. Digby Wheeler, Seconded by Dr. N. G. Trimble: "THAT the Treasurer's and Auditor's reports be adopted." Carried.

**Business Arising From Treasurer's and Auditor's
Reports**

Motion:

Moved by Dr. T. Digby Wheeler, Seconded by Dr. A. A. Alford: "THAT the sum of \$1,000.00 be invested in the current War Loan, the funds to be taken from the uninvested monies in the Savings Account of the Gordon Bell Memorial Fund. This \$1,000.00 bond is not to be added to the principal sum of the Gordon Bell Memorial Fund, but to be available for disbursement as a fellowship when required." Carried.

**4. Reports of Standing Committees and Their
Consideration.**

(a) Executive Committee.

No meeting.

(b) Registration Committee.

Dr. W. G. Campbell submitted the following report:

"As Chairman of the Registration Committee, I beg to report the following:

"Since the meeting of the Council on May 18th, 1945, this Committee has held nine meetings, at which fourteen applicants were given consideration. Reports have been sent to each member of the Council covering eight meetings, and I now report on the ninth, held on October 12th, 1945 (see report of Registration Committee).

"May I thank the members of this Committee for their co-operation in dealing with the various applications that were submitted. It is frequently necessary that prompt action be taken in deliberation on these applications to facilitate their registration."

Motion:

Moved by Dr. W. G. Campbell, Seconded by Dr. J. S. Poole: "THAT the report of the Registration Committee be accepted." Carried.

**Business Arising from the Minutes of the
Registration Committee**

**1. Re Resolution Passed at the Meeting of the
Registration Committee on September 21, 1945.**

Motion:

Moved by Dr. N. G. Trimble, Seconded by Dr. A. A. Alford: "THAT the resolution passed at the meeting of the Registration Committee on September 21, 1945, be accepted." Carried.

2. Re Registration of Dr. Henri Schaffer.

See report of Registration Committee, November 9th, 1945.

3. Re Registration of Dr. Nicholas Farkas.

Motion:

Moved by Dr. J. S. Poole, Seconded by Dr. H. O. McDiarmid: "THAT as Dr. Nicholas Farkas has been employed by the Rural Municipality of Pilot Mound during the emergency of war, that he be asked to attend the Medical College for one year, and to write the fourth year examinations. If he is successful, this College may then grant him an enabling certificate to write the examinations of the Medical Council of Canada." Carried.

(c) Education Committee.

At the May meeting of the Council, the Education Committee was instructed to consider how highly qualified specialists may be licensed to practice in the Province of Manitoba. Dr. A. A. Alford gave the following report:

**Re Educational Committee Report on Admission
of Specialists to the College of Physicians
and Surgeons**

1. After much investigation it would appear that the only standard of admission which would be absolutely fair and unimpeachable, should be scholarship and with it is implied the proper moral character of the applicant.

2. It does not appear that a by-law could be formulated which would cover all cases of specialists wishing admission to the College of Physicians and Surgeons. New qualifications would be advanced by applicants from time to time and it would appear that if admissions were made on a number of qualifications, the standard of admissions would be eventually lowered instead of being raised, until any so-called specialist could ask for admission.

3. The Council should approach the Dominion Medical Council, in view of having a universal standard of Registration across Canada. If a physician is good enough to practice in one part of Canada he should be good enough for any other part or province. This is an important matter and should be settled early owing to the advances in social medicine.

4. Under the Manitoba Medical Act, we believe the Council of the College of Physicians and Surgeons have the authority to admit members to the College and to decide on their qualifications and it would appear at this time, that the Council should assume that responsibility under the following provisions:

- (a) Applicants must have scholarship standing equal to Manitoba University standing for Medical students.
- (b) Applicants must have a recommendation from the licensing body of the province from which they come.
- (c) Applicants must furnish evidence of ten years' successful practice in Medicine or Surgery.
- (d) Applicant's admission to the College of Physicians and Surgeons must be passed at regular meetings of the Council after notice of motion has been given six months previously, and must pass by a four-fifths majority of the total Council.

5. We consider paragraph four to be logical in that there is no by-law or regulation attached to it regarding eminent specialists and every case is passed on its merits, and it would be understood that the accepting a certain member would not in any way set up a precedent. We must as a Council admit that by-laws set down years ago become obsolete, and owing to the rapid and divergent advances in Medicine and surgery we must set up a more flexible system of admissions to eminent specialists if they can comply with the provisions of paragraph four.

Signed,

W. F. Stevenson,
Brian D. Best,
A. A. Alford,

Educational Committee.

Motion:

Moved by Dr. N. G. Trimble, Seconded by Dr. W. G. Campbell: "THAT a copy of this report

be sent to each member of the Council for study and deliberation at the next meeting." Carried.

(d) Finance Committee.

Dr. T. Digby Wheeler suggested that this report be incorporated with the Treasurer's and Auditor's reports.

(e) Legislative Committee.

No meeting.

(f) Library Committee.

Dr. H. Bruce Chown presented the Library Statistics (as compiled by the Librarian, Miss Ruth D. Monk).

Motion:

Moved by Dr. H. Bruce Chown, Seconded by Dr. B. D. Best: "THAT the report of the Library Committee be adopted." Carried.

(g) Discipline Committee.

No meeting.

(h) Taxing Committee.

No meeting.

5. Report of Special Committees and Their Consideration.

(a) Representatives to the Manitoba Medical Association Executive.

As one of your representatives to the Executive Committee of the Manitoba Medical Association, I beg to report that this Association has been very active in the past year dealing with such important matters as:

1. Manitoba Medical Service.
2. The economics of the medical practise, particularly referring to the Government Health Plan.
3. Organization of the municipal doctors.
4. Establishment of the revised schedule of fees.
5. Improved co-operation with the Workmen's Compensation Board.

All of which are outlined in the report of the Association as submitted at its annual meeting on September 26th, 1945.

May I draw the attention of the Council to the fact that at the annual meeting, the report of the Legislative Committee, of which Dr. C. R. Rice is Chairman, was withdrawn by the Chairman on account of the unsatisfactory developments following the passing of the Basic Science Act.

Dr. W. G. Campbell.

Dr. H. O. McDiarmid.

Motion:

Moved by Dr. W. G. Campbell, Seconded by Dr. H. O. McDiarmid: "THAT the report of the representatives to the Manitoba Medical Association be adopted." Carried.

(b) Trustees of the Gordon Bell Memorial.

Dr. W. G. Campbell stated that there had been no report prepared. Dr. H. V. Rice had given up his research. At the present time there is no fellow, and no prospect of any.

(c) **Representatives to the Committee of Twelve.**
Dr. T. Digby Wheeler presented the following report:

"The following report of your representatives on the Committee of Twelve is submitted.

"Since the last meeting of this Council there have been held only three meetings of this Committee. It is felt that the major portion of their work had been done prior to the last meeting of the Council. As you will recall, the Basic Science Bill was put through as a Government measure at the last session of the Provincial Legislature. Your Committee had devoted a great deal of study and time to the preparation of this bill and we were certain that the bill, when it was passed, would meet all requirements and give all necessary safeguards. This bill has been enacted as law in the Province of Manitoba and the examiners in the Basic Sciences have been appointed by Order in Council of the Department of Health. It was our understanding that these would be entirely University appointments and examinations would be held under the aegis of the University of Manitoba. Your Committee is not at all satisfied with personnel as named by the Government to prepare the examinations in these primary subjects and it is felt that there will be some effort made to establish two standards. One, for the irregulars, and one, very much higher, for those entering the Medical Profession. It is proposed to hold another meeting of the entire Committee of Twelve in the very near future which the Minister of Health and the Deputy Minister will be asked to attend and at which we will have the assistance of our legal counsel."

Dr. T. Digby Wheeler.

Motion:

Moved by Dr. T. Digby Wheeler, Seconded by Dr. A. A. Alford: "THAT the report of the Committee of Twelve be adopted." Carried.

Dr. F. W. Jackson, Deputy Minister of Health, appeared before the Council to discuss the formation of the administration of the Basic Science Act.

He stated that the report of the Committee of Twelve was incorrect in so far as there had not been a board of examiners appointed at all. He stated that under the legislation, the Lieutenant-Governor-in-Council sets up the standards of the Basic Sciences, under section 10 (c) of the Act, "prescribing the extent to which persons to whom a certificate of credit is issued shall be required to be qualified in, or to be examined in, the basic sciences." He said that the Government through the Department of Health wrote to the acting president of the University of Manitoba, Dr. Armes, asking if he would suggest some names that might assist the Government in preparing a schedule of basic sciences. He said that there

was no provision in the Act for the setting up of a schedule by the board, and that the granting of licenses lies wholly with the University. The Government sets up the standards of the basic sciences. It sets up the required number of hours and the texts to be used in which a person has to be qualified, the type of work they have to do, and the type of examination they have to take. Dr. Jackson stated that a letter had been sent to the men picked from the names forwarded by the acting President of the University, Dr. Armes, with a plan of a schedule of basic sciences to assist them in drawing up a schedule of basic sciences. He stated that the bill was brought in through the Department of Health, but that its enforcement would be under the Attorney-General's Department once the schedule was set up. To a question as to who would set the examination, he stated that the University would be the one to set them. He also stated that the Act would be in force by the 1st of January, 1946, so that applicants for registration with the College of Physicians and Surgeons would be able to get their certificate at that time.

Dr. H. Bruce Chown, President, thanked Dr. F. W. Jackson for appearing before the Council. Dr. Jackson withdrew from the meeting.

Motion:

Moved by Dr. B. D. Best, Seconded by Dr. W. G. Campbell: "THAT this Council assembled request that steps be taken to establish the necessary regulations under the Basic Science Act providing the administration whereby graduates in medicine eligible for registration in the Province of Manitoba, may be assured of obtaining their certificates from the University of Manitoba, according to the requirements of the basic sciences, on and after January 1, 1946, under Section 7 of the Act. Bill No. 63, 1945." Carried.

Manitoba Medical Service

(Continued from Page 237)

As will be noted all the increase is to Plan B. Experience of the Plan A is good, but the same cannot hold for the B Plan. Numerous suggestions have been made to correct this, and it has been finally decided to increase the percentage enrolment from 40% to 75% on the Plan B, it being hoped that by this method the higher percentage will bring in a larger number of healthy people to balance the poorer risks.

A. G. Richardson,
Manager.

The learning and knowledge that we have is at the most but little compared with that of which we are ignorant.—Plato.

Hemobrom

Each tablet contains: Brominated Blood Albumin, $4\frac{1}{2}$ grains, Sodium Bromide, $\frac{1}{2}$ grain; plus excipient and coating. The bromide content is 33.58% corresponding to half the bromide content of potassium bromide.

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Sulfosalyl may be advantageously used in CHRONIC RHEUMATISM and ARTHRITIS and in other conditions of rheumatic origin, including SCIATICA and MUSCULAR ACHES and PAINS.

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As a supplement to the diet in conditions of vitamin and mineral deficiency, the use of these capsules will be found to improve general health and in many cases will assist the action of the drugs employed in therapy.

ONE OF EACH PER DAY

How Supplied: In boxes of 100 capsules. 50 Vitamins (Green). 50 Minerals (White).